CERTIFICATE OF NEED COMMISSION MEETING

Tuesday, March 9, 2004
9:00 A.M.

Holiday Inn - Lansing West Conference Center
American Room
7501 West Saginaw Highway,
Lansing, Michigan 48917

APPROVED TRANSCRIPT

MEMBERS PRESENT:
Renee Turner-Bailey, Chairperson
Peter Ajluni, D.O. (via conference call)
Richard Breon
Bradley Cory
James K. Delaney
Dorothy Deremo (via conference call)
Edward G. Goldman (arrival 10am)
Norma Hagenow (via conference call)
James Maitland
Michael Sandler, M.D.
Michael Young, D.O.

Department of Attorney General Staff Present:
Ronald Styka

Michigan Department of Community Health
Jan Christensen
William J. Hart, Jr.
Larry Horvath
Brenda Rogers

General Public Attendance:

Approximately 62 people in attendance.

CHAIRPERSON TURNER-BAILEY: Good morning. Apparently our mikes are not working yet so I'm going to go by big voice for a while, until we get that going. It's 9:15, and I'm calling the March 9th meeting of the Certificate of Need Commission to order. I would like to welcome everyone to the first regularly scheduled meeting of the CON Commission for 2004. And our first order of business is introduction of Commissioners and Staff because we do have some new staff. We do have a new commissioner. Good morning, Commissioner Deremo.

COMMISSIONER DEREMO: Hi.

CHAIRPERSON TURNER-BAILEY: Okay. We're going to have to work something out here. We've got two commissioners on the phone, one of which is a new commissioner and we'd like to introduce you. Unfortunately she's out of town and on the phone, but Commissioner Deremo, we'd like to welcome you.

COMMISSIONER DEREMO: Thank you. I would like to be there, I'm sure everyone's doing a good job.

CHAIRPERSON TURNER-BAILEY: We're going to have to work out some way to get you on the speaker, but in the meantime we're going to just keep rolling along. The next order of business would be the agenda. Are there any suggestions for additions or changes to the agenda?

COMMISSIONER MAITLAND: I would ask that because we're sort of short of commissioners here, I would like the election of officers to --

MR. NASH: Excuse. Could everyone please speak loudly while we try to figure out the problem, and this is mainly for the court reporter not me.

CHAIRPERSON TURNER-BAILEY: Okay.

COMMISSIONER MAITLAND: I would ask that the election of officers be moved to right after Item V, and probably if we do agree to do that then the election would take effect the first -- the next meeting that we have rather than changing officers right after that.

CHAIRPERSON TURNER-BAILEY: Is that a motion?

COMMISSIONER MAITLAND: I so move.

CHAIRPERSON TURNER-BAILEY: Okay. Is there a support for moving the election officers up the agenda to accommodate those commissioners who have to leave? Any discussions? All those in favor signify by raising your right hand, on the phone an Aye would be sufficient. Okay. Seven and one on the phone, eight.

COMMISSIONER DEREMO: There's two on the phone.

COMMISSIONER TURNER-BAILEY: Okay. Two. Nine agree. So we'll move that up to next Item VI. Any declaration of conflict of interests.

COMMISSIONER SANDLER: I don't believe it's a conflict of interest. I would state the following on the employment of the institution that has a PET scan, has an MRI, has a CT, has (inaudible) and actually has hospital beds. Most hospitals do have hospital beds actually. And, therefore, although I think there is a potential conflict of interest I don't believe there is a conflict of interest for any of those.

CHAIRPERSON TURNER-BAILEY: Thank you.

COMMISSIONER MAITLAND: I serve on North live Ambulance Service for months as a subsidiary of Bronson Hospital which has air ambulance helicopter. I don't feel that there's anything we would be discussing (inaudible).

CHAIRPERSON TURNER-BAILEY: Commission Breon.

COMMISSIONER BREON: I, like Dr. Sandler, (inaudible) as an MRI (inaudible) as well. Although I don't think there's a conflict.

COMMISSIONER DEREMO: I serve on the board of Oakland Health Systems. And is it also has many services that would (inaudible).

COMMISSIONER AJLUNI: I sit on the board of (inaudible).

CHAIRPERSON TURNER-BAILEY: Any further declarations of conflicts of interest? Thank you. Hearing none, at this time if you would just take a few moments, I'm assuming we would have done this actually prior to the meeting, to review the minutes of the February 26th, 2004, Special Commission Meeting.

COMMISSIONER SANDLER: I'm going to ask for one minor editorial change on declarations of conflicts of interest "Dr. Sandler stated that he knows Dr. and Mrs. Lonnie Joe". Could the minutes be changed to state that I know Dr. Lonnie Joe and his wife Dr. Annette Joe? I know her as a physician so since she is a physician why don't we have it as Dr. Lonnie Joe and Dr. Annette Joe, I don't want to get in any trouble here.

CHAIRPERSON TURNER-BAILEY: Okay. Okay.

COMMISSIONER MAITLAND: I move to amend the approval of that change.

CHAIRPERSON TURNER-BAILEY: It's been moved and supported that the minutes of the February 26th Commission meeting be accepted with the editorial change submitted by Commissioner Sandler. All those in favor raise your right hand. On the phone.

COMMISSIONER DEREMO: Aye.

COMMISSIONER AJLUNI: Aye.

CHAIRPERSON TURNER-BAILEY: Two ayes on the phone. And it's unanimous.

COMMISSIONER SANDLER: Can I ask a pertinent question? We don't have the verbatim minutes, we don't just have them yet, and we don't them period?

MS. ROGERS: No.

COMMISSIONER SANDLER: Okay.

CHAIRPERSON TURNER-BAILEY: And that in fact is not required, and we just doing that doing that really because of the complexity of the issues that we're dealing with. So as discussed previously we will now move on to election of officers. We need to elect, because of the bylaws that require us to have our elections at this meeting, a chairperson for a one-year term and a vice chairperson for a one-year term. So we will take nominations.

COMMISSIONER MAITLAND: I move that Renee Taylor-Bailey be nominated for chairperson.

CHAIRPERSON TURNER-BAILEY: Do I have to accept that?

COMMISSIONER SANDLER: I'll second the nomination.

CHAIRPERSON TURNER-BAILEY: Okay. There's been a nomination from the floor for chair for Renee Turner-Bailey. She's accepted. And the second.

COMMISSIONER BREON: I move to close the nominations.

CHAIRPERSON TURNER-BAILEY: There's been a motion to close the nominations by Commissioner Breon. Is there support?

COMMISSIONER SANDLER: Support.

CHAIRPERSON TURNER-BAILEY: Support. All those in favor, since there's only one running as Renee Turner-Bailey continuing as chair, please raise your right hand. The phone.

COMMISSIONER DEREMO: Aye.

COMMISSIONER AJLUNI: Aye.

CHAIRPERSON TURNER-BAILEY: It's unanimous. I will now take nominations for vice chair.

COMMISSIONER DELANEY: I nominate James Maitland as vice chair.

CHAIRPERSON TURNER-BAILEY: James Maitland has been nominated for vice chair. Commissioner Sandler.

COMMISSIONER SANDLER: Although normally Commissioner Hagenow could not be present here today because, she has had a hip replacement, I have been told that she is interested in running for vice chair to put a person like herself who has not had this opportunity. And she said she would like this opportunity to be vice chair of the Commission.

CHAIRPERSON TURNER-BAILEY: Is that a nomination?

COMMISSIONER SANDLER: That's a definite nomination.

CHAIRPERSON TURNER-BAILEY: Commissioner Hagenow has joined us on the phone. Welcome.

COMMISSIONER HAGENOW: Thank you. And are we correct in the assumption that you're accepting that nomination?

COMMISSIONER HAGENOW: Yes.

CHAIRPERSON TURNER-BAILEY: Okay. Any further nominations? (No response). Hearing none, is there a motion to close the nominations?

COMMISSIONER BREON: So moved turn.

CHAIRPERSON TURNER-BAILEY: So moved by Commissioner Breon.

COMMISSIONER SANDLER: Support.

CHAIRPERSON TAYLOR-BAILEY: Support by Commissioner Sandler. All those in favor raise your right hand. Those on the phone.

COMMISSIONER HAGENOW: Aye.

COMMISSIONER AJLUNI: Aye.

CHAIRPERSON TURNER-BAILEY: Okay. Got two on the phone.

COMMISSIONER DEREMO: Okay. It's unanimous. I will take at this time votes for Commissioner James Maitland as vice chair. And then finally I'll take votes for Commissioner Hagenow as vice chair. All those in who would like to vote for Commissioner James Maitland as vice chair of the CON Commission, please raise your right hand. And I will take folks on the phone immediately following. Four. On the phone, I'm going to ask you to give me an aye for Commissioner Maitland.

COMMISSIONER MAITLAND: Aye.

CHAIRPERSON TURNER-BAILEY: Okay. We've got one vote on the phone. Five for Commissioner Maitland. Votes for Commissioner Hagenow as vice chair. Please raise your right hand and I will take votes on the phone in a moment. Three. On the phone.

COMMISSIONER DEREMO: Aye.

COMMISSIONER HAGENOW: I'm not sure that I can vote for myself, if I can.

CHAIRPERSON TURNER-BAILEY: You can.

CHAIRPERSON HAGENOW: I want the position so I'll say aye.

COMMISSIONER TURNER-BAILEY: Okay. So that's five. Five and five --

MR. STYKA: You need to reopen the nominations or take further action because you don't have a vice chair yet.

CHAIRPERSON TURNER-BAILEY: Okay. We're going to reopen the nominations and we'll vote again.

COMMISSIONER MAITLAND: I'll tell you what, I'll withdraw. I've been chair before. It's not that much fun. (Laughter).

CHAIRPERSON TURNER-BAILEY: Okay. We have heard from Commissioner Maitland who has agreed to withdraw his name from the nominations in an effort to give one of the new commissioners some experience in this area, which I think is okay. So, Commissioner Hagenow, you're going to be the sole person running for this. I need to take one more vote and we'll go from there. So all those in favor of Commissioner Hagenow serving as vice chair of the Certificate of Need Commission, please raise right your hand. And on the phone.

COMMISSIONER AJLUNI: Aye.

COMMISSIONER DEREMO: Aye.

COMMISSIONER HAGENOW: Aye.

CHAIRPERSON TURNER-BAILEY: It's unanimous. Congratulations, Commissioner Hagenow.

COMMISSIONER HAGENOW: And from Maitland's words, I'm sure it's going to be a great privilege. I want to say I'm sorry I can't be there today. I'm just finishing my third week of post-op knee surgery but I highly recommend it for anybody because it's been most successful so I'll be there the next time around.

CHAIRPERSON TURNER-BAILEY: Excellent. And we're glad you're having a most successful recovery. Thank you.

COMMISSIONER HAGENOW: Thank you.

CHAIRPERSON TURNER-BAILEY: Commissioner Sandler.

COMMISSIONER SANDLER: I'd like to thank Commissioner Maitland for his graciousness in breaking the deadlock. Thank you.

CHAIRPERSON TURNER-BAILEY: Next order of business, we have, as you can see, multiple areas that we need to deal with. And these are generally -- Brenda, I'm going to let you explain what we're doing here. But these are generally the positions of Medicaid and Rural Language; is that correct?

MS. ROGERS: That is correct.

CHAIRPERSON TURNER-BAILEY: Okay. Would you walk us through that, please? And just everyone knows we have to vote on each of these individually, so we're going to be a moment.

MS. ROGERS: This is Brenda Rogers. There have been no substantive changes since these went out for the public hearing, or any action taken at the December meeting. The only change that I would suggest is for the Nursing Home Standards, it references the Department of Consumer and Industry Services in there in a couple of different places. And I would ask for an amendment to be added that this be changed to the Michigan Department of Community Health now as a result of the reorganization. On all of these standards, again, in dealing with the Medicaid language under 619 as well the Rural Definitions, so we are now adding the Metropolitan Statistical Area County and the Micropolitan Statistical Area County. And the micropolitan will be incorporated together with the Rural Exceptions and Theory of Standards. Unless you have any other question.

COMMISSIONER DEREMO: This is Commissioner Deremo on the phone.

CHAIRPERSON TURNER-BAILEY: Okay. Okay. Commissioner Deremo.

COMMISSIONER DEREMO: Looking through the material I noticed how (inaudible) put a proposal on the table on identifying the level of Medicaid participation to be 75 percent of the percent of Medicaid participation in the county. And I'm wondering as a new commissioner was that discussion not discussed and how that impacts or does not impact that the language that I reviewed in the documents that were sent.

CHAIRPERSON TURNER-BAILEY: Did you hear the question?

COMMISSIONER SANDLER: MR. Breon, I believe, made a proposal to which was given to us in writing about the Medicaid participation. She's questioning where does that fit into these (inaudible). Do we need to vote on -- I think what she's trying to do is do we need to vote on this first or how does this work, in other words?

MS. ROGERS: At this point, that language that was given to the commissioners back at the December meeting, there was some discussion on that. The department is not asking for an amendment to add that language. If the Commission chooses to incorporate that language or some variation, you can do that today by modifying what's been given to you. The department is just proposing the language as presented at the December meeting.

COMMISSIONER DEREMO: Was there any debate or discussion about the amount of Medicaid participation in the southern area that applicants need to have, or just that they participate in Medicaid in order for their application that that was one of the criteria for consideration?

CHAIRPERSON TURNER-BAILEY: MR. Horvath.

MR. HORVATH: Currently the way the department will operationalize this is that we will ask that any applicant to provide to the department what they call a Medicaid turnaround letter which means that they have now enrolled in the Medicaid program. It doesn't have a level of participation. What it basically means is the applicant has been certified by Medicare, they have their license, they have their Certificate of Need approval, and so there is some minimal threshold but it doesn't have a level of participation. The only level of participation that will occur is that if the applicant hasn't billed Medicaid in the last two years that provider number will have been closed out and they'll have to re-bill through the system to prove to the department that they are participating. But there's no minimal level. If an applicant is a new applicant then the department will place a stipulation on the CON approval saying that 'before you start operation you must submit a letter from the Medicaid program showing that you are enrolled', so that's the current procedure those will be using.

CHAIRPERSON TURNER-BAILEY: Commissioner Breon.

COMMISSIONER BREON: I don't have a microphone but I'll talk loud. This is Breon. The reason that we brought up the level of participation because as the language reads it's very difficult to figure out what you have to do. And I think we're trying to add some clarification. I think what it also proves that it was very difficult to come up with language that we could operationalize. So I think was the struggle. And we don't have any trouble with the language as written. It's for the owners on the department to come up with what is the level of participation, what is acceptable. I think that's what the whole idea was behind the other language was trying to find something that gave some teeth to this otherwise conflict so it's rather toothless. Even though it's an initial threshold it really doesn't mean a lot.

COMMISSIONER DEREMO: If I could -- it sounds to me like these are minimal standards but that there was not an effort within the language to an organizations that are providing a disproportionate share of Medicaid services in their area or county, is that -- my question correct?

MR. HORVATH: That is correct.

CHAIRPERSON TURNER-BAILEY: That is correct. Are there any further questions?

MR. STYKA: Could you repeat the last -- I didn't hear what she said.

CHAIRPERSON TURNER-BAILEY: Commissioner Deremo, can you repeat your last comment?

COMMISSIONER DEREMO: Yes. From the discussions, and I apologize guys for taking the Commission's time, I'm just trying to understand. That it terms of the language that has been inserted for the CON review standards for the various services that Medicaid considered one of the minimum criteria for an applicant in order to apply, but so the floor has that minimum whereas the language that (inaudible) by Spectrum Health was trying to get at the issue that within a service area there may be service providers that are providing their fair share of Medicaid services where there may be other providers in that service area that are not taking an equal share of Medicaid. But, commissioner Breon, did I get that correct?

COMMISSIONER BREON: Yes.

COMMISSIONER DEREMO: In terms of the language, my question was has there been any discussion around that issue as a consideration for a minimal standard? And what I heard from the Department was that that had not been considered in the minimum language that this is for. Did I restate everything appropriately as to how I understood it.

CHAIRPERSON TURNER-BAILEY: That question was for you, right?

COMMISSIONER BREON: Yes. The question was to me, I'm sorry. Yes, I think you did restate it accurately. I think the department did consider that. And actually we were working in we're trying to find something to put in there, and it's difficult to do. But I think at end it was both certainly accomplished. It was considered and decided to go with the minimum standard.

COMMISSIONER DEREMO: Thank you.

COMMISSIONER SANDLER: I'm slightly confused by this discussion. Are we leading up to discuss this again? I'm not certain what's --

CHAIRPERSON TURNER-BAILEY:I think she just needed some clarification.

COMMISSIONER SANDLER: It's not included in this standard at all?

MS. ROGERS: No. Nobody's made a motion.

CHAIRPERSON TURNER-BAILEY: Any further questions or discussion on this language? (No response). I accept a motion at this time on -- as I said, we have to go through each one individually. And the first one is Air Ambulance Services. Commissioner Sandler.

COMMISSIONER SANDLER: My motion is to approve the departmental language for Air Ambulance Service.

CHAIRPERSON TURNER-BAILEY: There's been a motion to approve the departmental language for Air Ambulance Service. Is there support. (Support).

CHAIRPERSON TURNER-BAILEY: There's support. All those in favor --

MR. HOROWITZ: Madame Chairperson.

CHAIRPERSON TURNER-BAILEY: I'm sorry.

MR. HOROWITZ: Are you going to take public comments on this item?

CHAIRPERSON TURNER-BAILEY: Larry Horowitz.

MR. HOROWITZ: Larry Horowitz of Economic Alliance. I certainly can understand why the fact that it could be called in as status quo. This is a hard thing to operationalize. I'm Larry Horowitz with the

Economic Alliance for Michigan. It's very brief. I understand why you're developing to the status quo language. I would just indicate that I don't think this is consonant, however, with the requirements of the revised 2002 language in which this it says that Medicaid participation shall be a factor of waiting and is very important. And I don't think you can then say since I know of no hospital in Michigan, just about no hospital in Michigan who isn't Medicaid eligible, because in order to qualify for Medicare money you have to be eligible for Medicaid. So I'm just urging the Commission that when it next looks at these standards in a timely way to look at the question of figuring out some waiting system so that the hopefully the department and other interested parties do come forward to do that. There is such a waiting system, for example, in the nursing home standards where a number of Medicaid patients are actually being served, broken down by I think quintals, 20, 40, 60, so forth, is (sic) differential comparative viewpoints. We don't have that. I think the urge that that be considered in a timely fashion, so I certainly don't have any objection to the motion now before you. Thank you.

CHAIRPERSON TURNER-BAILEY: Mr. Styka.

MR. STYKA: Yes. The statutory section that was referenced by the speaker deals with comparative reviews. As I understand it, all we're doing at this point is amending the standards to include what the legislature require in terms of requiring that all applicants participate in Medicaid. At a later time or at the appropriate time, we can deal with the comparative review issue, which is where we talk about waiting for participation. But this is in relation to any applicant and the threshold to be an applicant.

MR. HORVATH: I can understand that. It's just that some of the standards that you're about to act on are standards that require comparative view. To that extent, therefore, you're not addressing what I would think was the clear and legislative intent understanding it's not -- reasonably now it's far better to do -- to accomplish -- part of what the legislature wanted you to do if you can't do it all right away. I'm just pointing out that some of these standards are comparative standards and we don't have something that would meet that criteria.

MR. STYKA: I would point out that the provision on comparative review is not a new provision for 2002. We've always had to way comparative reviews in Medicaid.

CHAIRPERSON TURNER-BAILEY: Thank you. Any other questions or comments? (No response). Hearing none, all those in favor of the motion please signify by raising your right hand. On the phone.

COMMISSIONER AJLUNI: Aye.

COMMISSIONER DEREMO: Aye.

CHAIRPERSON TURNER-BAILEY: Commissioner Hagenow, are you still on the phone? Okay. She's not on the phone. Okay. Motion carries. I'll accept a similar motion for Bone Marrow Transportation Services.

COMMISSIONER BREON: Move.

CHAIRPERSON TURNER-BAILEY: Moved by Commissioner Breon.

COMMISSIONER DELANEY: Support.

CHAIRPERSON TURNER-BAILEY: Support by Commissioner Delaney. Any discussion? (No response). All those in favor signify by raising your right hand. On the phone.

COMMISSIONER AJLUNI: Aye.

COMMISSIONER DEREMO: Aye.

CHAIRPERSON TURNER-BAILEY: Cardiac Catheterization Services.

COMMISSIONER BREON: So moved.

CHAIRPERSON TURNER-BAILEY: Moved by Commissioner Breon. Is there support.

COMMISSIONER YOUNG: Support.

CHAIRPERSON TURNER-BAILEY: Support by Commissioner Young. Any discussion? (No response). All those in favor please signify by raising your right hand. On the phone. Okay. We've got eight again. Heart/Lung and Liver Transplantation Services.

COMMISSIONER MAITLAND: Moved by Maitland.

CHAIRPERSON TURNER-BAILEY: Moved by Maitland.

COMMISSIONER DELANEY: Support.

CHAIRPERSON TURNER-BAILEY: Support by Delaney. Any discussion? (No response). All those in favor please signify by raising your right hand. Six. On the phone.

COMMISSIONER DEREMO: Aye.

COMMISSIONER AJLUNI: Aye.

CHAIRPERSON TURNER-BAILEY: Magnetic Resonance Imaging Services. Is there a motion.

COMMISSIONER DELANEY: Moved.

COMMISSIONER MAITLAND: Support.

CHAIRPERSON TURNER-BAILEY: Moved by Commissioner Delaney. Support by Commissioner Maitland. Any discussion? (No response). All those in favor raise your right hand. On the phone.

COMMISSIONER AJLUNI: Aye.

COMMISSIONER DEREMO: Aye.

CHAIRPERSON TURNER-BAILEY: Unanimous. Neonatal Intensive Care Services and Beds.

COMMISSIONER MAITLAND: Moved by Maitland.

CHAIRPERSON TURNER-BAILEY: Moved by Maitland.

COMMISSIONER YOUNG: Support.

CHAIRPERSON TURNER-BAILEY: Support by Commissioner Young. Any discussion? (No response). All those this favor raise your right hand. Six. On the phone.

COMMISSIONER AJLUNI: Aye.

COMMISSIONER DEREMO: Aye.

CHAIRPERSON TURNER-BAILEY: Eight. Nursing Home and Hospital Long-term Care Unit Beds. Is there a motion.

COMMISSIONER DELANEY: Moved.

CHAIRPERSON TURNER-BAILEY: Moved by Commissioner Delaney.

COMMISSIONER YOUNG: Support.

CHAIRPERSON TURNER-BAILEY: Support by Commissioner Young. Any discussions? I'm sorry.

MS. ROGERS: Does that motion include the amendment to change Consumer Industry Services to the Department of Community Health?

COMMISSIONER YOUNG: Yes.

CHAIRPERSON TURNER-BAILEY: Thank you for reminding us. Let's go back. All those in favor raise your right hand. Six on. On the phone.

COMMISSIONER DEREMO: Aye.

CHAIRPERSON TURNER-BAILEY: Okay. Seven. Open Heart Surgery Services. Is there a motion?

COMMISSIONER YOUNG: So moved.

COMMISSIONER BREON: Support.

CHAIRPERSON TURNER-BAILEY: Moved by Commissioner Young. Support by Commissioner Breon. Any discussion? All those in favor raise your hand. On the phone.

COMMISSIONER DEREMO: Aye.

COMMISSIONER AJLUNI: Aye.

CHAIRPERSON TURNER-BAILEY: Okay. Eight. Pancreas Transplantation Services. Is there a motion?

COMMISSIONER MAITLAND: Moved by Maitland.

CHAIRPERSON TURNER-BAILEY: Moved by Maitland.

COMMISSIONER DELANEY: Support.

CHAIRPERSON TURNER-BAILEY: Support by Delaney. Any discussion? (No response). All those this favor raise your right hand. On the phone.

COMMISSIONER AJLUNI: Aye.

COMMISSIONER DEREMO: Aye.

CHAIRPERSON TURNER-BAILEY: Okay. That's nine. Positron Emission Tomography Scanner Services and Psychiatric Beds and Services. Is there a position on PET Scanner Services?

COMMISSIONER SANDLER: Moved.

COMMISSIONER MAITLAND: Support.

CHAIRPERSON TURNER-BAILEY: Moved by Commission Sandler. Support by Commissioner Maitland. Any discussion? (No response). All those this favor raise your right hand. On the phone.

COMMISSIONER DEREMO: Aye.

CHAIRPERSON TURNERY-BAILEY: Eight. Okay. Psychiatric Beds and Services. Is there a motion.

COMMISSIONER DELANEY: So moved.

CHAIRPERSON TURNER-BAILEY: Moved by Commissioner Delaney. Is there support?

COMMISSIONER YOUNG: Support.

CHAIRPERSON TURNER-BAILEY: Support by Commissioner Young. Any discussion? (No response). All those this favor raise your right hand. Okay. On the phone.

COMMISSIONER AJLUNI: Aye.

COMMISSIONER DEREMO: Aye.

CHAIRPERSON TURNER-BAILEY: Eight. Okay. That was a lot of work IN a very short period of time. Thank you very much, the Department, for getting those updated and correct. Next item on the agenda.

COMMISSIONER SANDLER: I have a question. I have a questions about this item for the assistant --

CHAIRPERSON TURNERY-BAILEY: Speak up, please.

COMMISSIONER SANDLER: I have a question for Ron Styka on this issue. My understanding is the day after, 45 days from today this report goes back; is that correct? Forty-five legislative days tomorrow. Would you please explain it.

MR. STYKA: Well, time starts to run, you have another procedure here to go through. Time is not going to run (inaudible). When's the department going to be doing this?

MS. ROGERS: The clock will start from the day of submission and the first day has to be a legislative day so, you know, as soon as we have these prepared and we have to put the report together for the (inaudible) so once that's put together, delivered to the legislative committee as well as the governor, that's when the clock will start. If it's on a legislative session day that's the first day. If it's not a legislative session day the clock will start whenever the first legislative session day is --

COMMISSIONER SANDLER: I'm not going to try to hold --

MR. STYKA: So the answer is you're(inaudible).

COMMISSIONER SANDLER: But my question is without holding you to the date what would be the likely the time frame we're talking about, two weeks from now it starts? When would you plan to submit it is my question?

MS. ROGERS: I would say probably within the next two weeks.

COMMISSIONER SANDLER: Okay. That's really for the next issue. Thank you so much.

CHAIRPERSON TURNER-BAILEY: Any other questions? CT Scanner Services. Commissioner Sandler, do you have a --

CHAIRPERSON TURNER-BAILEY: Okay. Amy Barkholz.

MS. BARKHOLZ: Good morning, I'm Amy Barkholz from the Michigan Hospital Association. Just briefly, I would ask the Department to support the proposed CT language and take final action on it. You may remember that actually this came up at the December CON Commission meeting. This is the language that would allow health low facilities with 24-hour emergency departments to acquire and replace a fixed CT scanner regardless of volume. It also addresses the issue of hybrid PET CT units and add some language allowing the relocation and transfer of ownership of CT. This was a very popular proposal. There was not a lot of controversy in dealing with it. And the only reason it got held up before was because of the technical changes that you just also added to all the other standards. So for that reason I hope there are folks waiting to act on these potential provisions. I hope you will take final action on it today. Thanks.

CHAIRPERSON TURNER-BAILEY: Any questions? (No response). Thank you. Greg Dobis.

MR. DOBIS: I'd like to thank the commission for the opportunity. I realize that this agenda item primarily deals with the Medicaid review in rural definition.

CHAIRPERSON TURNER-BAILEY: Before you start you need to state your name --

MR. DOBIS: I'm sorry. Greg Dobis. I represent McLaren Health Care Corporation out of Flint. I realize the agenda today this particular item goes with Medicaid Rural Definitions, and it does not specifically address some of the things that I'd like to talk about. And I will be brief. There is not an agenda item for the PET CT or mobile PET or fixed PET standards said on the Commission agenda items today. And also this is the month that it's my understanding, if I'm interpreting correctly, that PET standards are eligible for re-review and taking a look at how those standards are in effect and how they will affect some of the institutions around the state. I particularly would ask the Commission that they consider reviewing the standards as it relates to 85. What I call the 85/15 percent rule. And that is basically it has a major access in cost efficiency issue and implication for systems because of the planning area restrictions. Particularly in our case in McLaren we have one hospital that is not a subsidiary corporation that is not located had in the same planning area as the other two whole sites. We cannot adequately serve their population because we're restricted in only' serving 15 percent of their total volume. Also because of the lifetime commitment they're they ineligible as the standards are interpreted to receive service from the other mobile providers. It doesn't make any sense when we can give them 100 percent service at the corporation's cost versus even if we were allowed to having to go out outside out mobile PET route to offer them this type of service at most likely highly a much larger cost than the actual hospital itself, so I think that needs to be taken a very critical look at. Also, if adding a host site to an existing network it would be very helpful. There is a section that clearly is devoted to this on how that works and what the implications are, the rules are. The other two points I have are somewhat intertwined and tied together and that's adding host site to an existing and the commitment for life (inaudible). Once again we have been the application was supported by one of our subsidiary hospitals committed 100 percent of their data. We are ready. We would like to -- they have the volume to convert to an actual host site. The way the standards are written they're eligible to do that. They are committed to life. They can never, it's my understanding, never move into a host site situation regardless if it was with our corporate network or someone else out there to provide mobile service. Again poses a major problem particularly for our system. And that is tied into the commitment for life and mechanism. There is no clear mechanism in these standards to allowed for a conversion to a host site from an institution that supported the application with that only. And the fifth point is the relocation of the mobile host site location. Again, these standards have been in existence for two years. I think most people are starting to get up and running with their mobile PETs. In the two-year period, particularly as we notice a shift in outpatient type services, some of the locations were at the time deemed to be appropriate, they no longer are because of patient congestion as well as trying to get the best flow for patients into certain campuses. And I'm not talking about being allowed to put it at an office site, physician off site or something like that, it's just looking at being able to change the locations on campuses itself of the institution. I think there is a lot of precedence in the MRI standards that could possibly be mirrored as relates to PET. I think it would be worthwhile to take a look at. I don't believe it was ever the intent in probably three or four years ago we start talking about PET to make the standards so complicated and to possibly have restrictions in access in there to patients. And I would just request that the standards be discussed, that they would be reviewed, and with these points in mind I discussed. And I think there's actually some other institutions here today who want what to address the same issue, so I thank you very much for your time. If there are any questions?

CHAIRPERSON TURNERY-BAILEY: Are there any questions? (No response). Thank you. I don't have any other cards for public comment. Are there any discussion among the Commission.

COMMISSIONER SANDLER: Yes, I have just a brief discussion.

CHAIRPERSON TURNER-BAILEY: Commissioner Sandler.

COMMISSIONER SANDLER: Not in response to Mr. Dobis although he appears some appropriate points that perhaps the Department and the Commission could look at least patient congestion. But specifically

on the CT, I think this would be a significant improvement in rural health care. I just wanted to remind the Commission that we're voting on in terms of PET. This allows the following, if you have a CT/PET hybrid and that's the only thing that's being sold nowadays the (inaudible) find them anymore, this allows you to do a CT without doing a PET. If you can meet the requirement only you don't have do go through the (inaudible) process with volume. And the reason for that is the cost of this technology (inaudible) PET for starting up. And we restate the consensus on (inaudible). I would like to thank all the players for bringing up the rural CT and the PET CT for the hospitals, the physicians, the Economic Alliance and we appreciate the consensus support we've received. Thank you.

CHAIRPERSON TURNER-BAILEY: Thank you. Any other questions? (No response). Discussion? (No response). I'd like to welcome Commissioner Goldman. Is there a motion?

COMMISSIONER SANDLER: The motion would be to take final action on the CT standards. One other point I would like to make. The Department did ask that I review the minimum requirements. And they were updated. I think the other item was should we lower the volume requirements to obtain CT and to discussing it with the (inaudible) there is no evidence, there is not appropriate access now. So I recommend they not be to be voted, they be kept at the same requirement. The only thing I would ask the commissioners not today, not next week or the next couple of meetings, there is evidence to suggest CT would be replaced at diagnostic coronary cardiac catheterization. And then one more other test (inaudible) which will frankly save money and patients and (inaudible) at that time the next coup of years we may have to re-look at that.

CHAIRPERSON TURNER-BAILEY: Is there support for the motion to set the language?

COMMISSIONER BREON: Support.

CHAIRPERSON TURNER-BAILEY: Support by Commissioner Breon. Any further discussion? (No response). All those in favor please raise your right hand. On the phone.

COMMISSIONER DEREMO: Aye.

CHAIRPERSON TURNER-BAILEY: Okay. We've got eight. Okay. Motion carries.

MS. ROGERS: This is just a clarification on the motion. I'm assuming this motion and the previous motion includes moving forward for the 45 day.

COMMISSIONER SANDLER: That was my intent.

MS. ROGERS: Thank you.

COMMISSIONER SANDLER: That we'd like final action so particularly rural hospitals could begin to have CTs for trauma and others (inaudible).

CHAIRPERSON TURNER-BAILEY: Thank you. Hospital Beds-Subareas and Bed Need Methodology. Discussion? Okay. I'm going to call for public comment. James Ball.

MR. BALL: Good morning, my name is James Ball. I represent General Motors Corporation, and I represent Michigan Manufacturers Association on the Hospital Bed Ad Hoc. I don't have any written comments this morning. I was frankly sort of surprised to be called as quickly. I was expecting to hear comments from the Department and from the attorney general on issues that have been discussed at the prior meeting, so I'm going to sort of wing it at this point. And ask that depending on what I hear later on I might want to make further comments.

CHAIRPERSON TURNER-BAILEY: Okay.

MR. BALL: You've heard both -- I've written to the Commission members as has the Dale Steiger, we've written joint letters about the process that we were (inaudible) with regard to developing the standards. And this morning I'm urging you to adopt them and move them forward to give them final adoption to

move them forward. Are the standards that we proposed to you and you took initial action on, are they responsive to the charge? I believe so. Were they arrived at through a deliberative process and through objective discussions? I believe the answer to that is yes. They did not attempt to address and, in fact, we were counseled not to try to address issues of socioeconomic factors, if you will. We were instructed to stick to the area of subareas of Bed Need Methodology. I think the standards we proposed did make needed changes in the algorithms for calculating bed need and in the areas. Are they the final word on bed need? I suspect not. I see this morning on the table back there yet a new charge to some future group so I suspect they are not the final word, but I think that they should be adopted for at least the purposes that our committee was charged with. Thank you.

CHAIRPERSON TURNER-BAILEY: Any questions. (No response). Dale Steiger.

MR. STEIGER: Good morning. My name is Dale Steiger, and I'm here both as the chair of the Technical Advisory Committee as a member of Jim Ball's Bed Need Ad Hoc Committee. I too was kind of waiting for the department to discuss some sort of ruling that we were expecting from the attorney general's office. I had jokingly said yesterday that I was going to put together two sets of comments for and against, but I haven't put anything together in terms of no comment at this point. So once again I'm here to urge you to give final approval for these revisions which were recommended for the Bed Need Ad Hoc Committee and to which you gave initial approval at December the 2003 Commission meeting. At the last Commission meeting I thought Mr. Goldman had framed the issues quite nicely surrounding your approval of the Bed Need Methodology. He said that in his mind there were three issues that needed to be dealt with. No. 1 was issue of the legal review for rational basis, which we will assume hear later on. No. 2 was sending the proposed standards out for an independent outside review, and the third issue was the issue of having this standards updated and approved by November of 2003, the state law issue as Mr. Goldman referred to it. I'm here to tell you that the TAC standards ready to help you meet the state law requirement by recommending that you approve and adopt our work product. With respect to MR. Goldman's second point, the only outside review that was done that I'm aware of is Professor Griffith's review. And as I indicated to you and I e-mailed you back in February Professor Griffith's comments certainly seemed to support the efforts of the TAC. His quote was that: “Thus the concept of market term "subarea" per se has been accepted historically as meeting the rational basis test. I know of no better approach". So I'm hopeful that the department and the attorney general's office will agree with Professor Griffith and also with the rest of the TAC. But enough rational basis, that was the good news. But as you know in Professor Griffith's letter he also goes on to indicate that there may be a better mouse trap with regards to the Bed Need methodology. However, his first two bullets on page two basically agreeing with the data from the Michigan Inpatient Database use rates both admissions and monthly stays have declined over the last 25 years. There's certainly no argument there. He then goes on to make two suggestions as regards to treatment of specialty beds. And I would like to point out that he made these same comments a year and a half ago when he met with the TAC Novi. Quite frankly we have already had these issues on our issues list and have you report that we were way ahead of the curve. We handled this issue to the satisfaction of all of the providers on the TAC and the ad hoc by reducing target occupancies and by determining bed needs for OB and Peds separate from the rest of the medical surgical beds. Technical issues that we don't want to get into today and we discussed at the last Commission meeting. But the TAC also went one step further when it eliminated the normative approach for use rates and instead and substituted the use of actual age specific use rates that occurred in subareas. The question key word is "actual". We did this because MHA presented conclusive evidence that areas of the State with higher inpatient use pretty well correlate with areas of poor socioeconomic status. Because of a variety of factors over the years have greatly reduced use rates. The TAC on the bed need in these individual communities to reflect actual need and not a statewide average. I might also add that (inaudible) actual use rates plus the other methodological changes that the TAC implemented -- or recommended -- resulted in a net increase of 2,500 beds across the state of Michigan. So the new standards which we hope you will approve today indicate that the State has a need for 2,500 more beds than theoretically are needed under the standards that are currently in effect. As regards, Professor Griffith's other points on page and three, I don't necessarily disagree but the lofty criteria he mentions (inaudible) about being a full employment act for some consulting company could subject the Commission to endless court challenges as different applicants come in for beds. What the Bed Need Ad Hoc group is urging you to approve is a tangible product that currently exists and is based on patterns of care in this State and on the best population projections through 2006 and into the future that we have available. I would leave you with two thoughts. Professor Griffith said, and I quote: “It would be contrary to the best

interest of the people of Michigan to allow hospital construction that would not be cost effective and fiscally sound. "I certainly agree. But it goes without saying that something first must be needed before it can be cost effective or fiscally sound. The second thought Professor Griffith, and again I quote: “Not surprisingly, specific solutions are disputed by people who wish a different solution. "I'm sure you will hear lots of testimony later on today from folks who wish a different solution, but remember this tax recommendation (inaudible) a different solution, they wish to correct solution. And we hope you will agree with that and will adopt those standards. Thank you.

CHAIRPERSON TURNER-BAILEY: Thank you. Are there any questions? (No response). Patrick O'Donovan. MR. O'Donovan, give me one moment because I'm going to let Mr. Christensen make a comment. I'll call you in just a second.

MR. CHRISTENSEN: Thank you, Madame Chair. Since the previous two speakers referenced where the department stands, I appreciate the opportunity to find some -- (inaudible). We certainty would agree that the standards are not the final issue. We also agree that the committee, the TAC Committee, the Ad Hoc Committee, did a yeoman's piece of work of pulling together the information that they had and the charge that they had to carry that out. We do have reservations with that and not being shy about talking of the Commission in December but looked at it as a total package. Another item on your agenda here calls for the discussion of a charge that would create a committee that would look at the access to care issues which we think are not directly addressed in the current proposed item before you in terms of the present methodology. We can support it in the concept of it's a product, it delivered a particular advance to the existing standard. It updated as the speakers had indicated, the two previous speakers had indicated, relevant data in terms of that but it didn't go quite far enough for us. But there is a strong support for approval for the charge to the committee to continue over the next six months looking at the access to care issue and bringing recommendations back to this Commission. We certainly can support the passage acknowledge of this first piece of what we think is a ultimately a larger package of issues that deals with all of the issues including access to care issue. So we're not opposed to the Commission passing the standard, and would encourage you to consider it but consider it only in the context of going further. It would be very, very difficult for the department to endorse the standard without an opportunity to look at the access to care which has not been adequately addressed as yet with specific language that we would like the Commission to consider.

CHAIRPERSON TURNER-BAILEY: Thank you. Are there any questions for Mr. Christensen? Any comments? (No response). Since we've stopped the public comment, Mr. Styka, and you did submit a letter responding to the Commission's request looking at legally sufficiency issues for that language. Would you mind following on that, please?

MR. STYKA: Well, I don't know if you want me to read the entire letter or just summarize it?

CHAIRPERSON TURNER-BAILEY: Can you give us a summary?

MR. STYKA: Well, I'll start with the conclusion. And my conclusion was whether the CON Commission adopts the proposed standards as a matter of policy to be determined. In doing so, the Commission most consider any comments on feasibility presented by the department and the legality presented by the attorney general. And as an your assigned counsel I do not find the proposed review standards to be legally deficient. In my letter I discussed the tests that are used to determine whether or not the promulgations are in fact valid. The court cases refer to the three-prong test -- I won't bother you with the citing the court's arguments, it's in your document. But the three-prong test is whether the rule, or in this case the standard, is within the matter covered by enabling statutes, which it is. If so, whether it complies with the underlying legislative intent, it does although there may be ways to improve it as Mr. Christensen has indicated. And (3) if it meets the first two requirements whether it is neither arbitrary nor capricious. The courts has also defined arbitrary and capricious as meaning contrary is without adequate determining principle fixed or arrived through an exercise and caprice, without consideration or adjustment with reference to principles, circumstances or significance, decisive but unreason. And capricious is apt to change suddenly, freakishly or humorously. With this background in law, I went into materials that were presented to me by staff at your request which included minutes of the committees and letters and documents that were submitted, and comments from the public; and of course the document itself, the proposed standard. And determined that I could easily defend the standards in court as meeting all the

tests that were laid out. I also looked at the issue of the so-called rational basis that people have been mentioning which really seeking protection issue. And the only way I see that having any concern in these proposed standards is with regard to the subareas. And, again, looking at the materials, looking at what the committee did and the minutes, etcetera, I did not find a problem there either. I did cite in my memorandum to you the case law in Equal Protection and the Michigan Constitution insures that similarly situated people will be treated alike, but it does not guarantee that people in different circumstances will be treated the same unless discrimination impinges on the exercise of fundamental right such as the speech, voting, etcetera, or involves a suspect class, which I do not find here. The inquiry under the Equal Protection Clause is whether the classification is related to a legitimate government purpose which obviously the subareas are. Specifically if you look at all the analysis of how they arrived at the them. So therefore I did not find that there was any problem using that test or even the rational basis test because obviously when you look at the materials there is a rational basis for what the committee did and what the committee recommended. It's interesting that I cited in my letter with a little extra the sentence that was confused by one of the committee chairs (inaudible) of MR. Griffith's letter, which I also had, but the concept of market determined subareas per se has been accepted historically as meeting the rational basis test, which I agree is true. I know of no better approach, he says. A similarly (inaudible) use of different market share factors is consistent with reality. And he says the urban market in Detroit simply does not resemble that of Grand Rapids let alone Marquette or Grayling. Indicating as an expert that there can be differences between how you calculate the subareas. And I think that added to the weight that there is no problem here with these proposed standards from a legal point of view. But policy-wise, it's solely in your hands as to whether or not these good standards, whether they're a first step, a last step or whatever.

CHAIRPERSON TURNER-BAILEY: Okay. Thank you. Are there any question for Mr. Styka? (No response). Thank you very much. I'm going to ask Mr. Ball and Mr. Steiger if you want to come back because you said you might have some other comments. I can uncheck the cards.

MR. BALL: I yield to the brilliant wisdom of Mr. Styka.

CHAIRPERSON TURNER-BAILEY: Okay. Thank you.

MR. BALL: I just want to say that my son, he's in his third year of law school would be thrilled that I'm not in violation of the 14th Amendment. (Laughter).

CHAIRPERSON TURNER-BAILEY: Patrick O'Donovan.

MR. O'DONOVAN: Good morning. My name is Patrick O'Donovan, Director of planning Beaumont Hospitals. I participated on both the ad hoc committee and the technical advisor committee that in developed the proposed bed standards that you approved for purposes of public comment back on December 9th. Beaumont supports these standards and we urge you to take final action today approving these standards. Beaumont supported these standards because they were developed using a comprehensive planning methodology that was supplied to determine hospital bed need throughout the state. We would hope that any further proposals to authorize new beds or new hospitals remain under the scrutiny of the CON process and are evaluated using radical planning criteria. An alleged shortcoming of the bed need methodology is that it doesn't account for population shifts within geographic areas served by groups of hospitals known as subareas. However, rather than relying on anecdotal evidence pertaining to bed need and bed distribution, this issue should be evaluated using valid quantitative planning methodology. For example, a drive time analysis would be one approach for looking at hospital access in various areas of the state where population shifts may be occurring. It's important to recognize that the bed need methodology in the proposed standards does take into account overall population growth within geographic areas served by hospital subareas. In recent months we've heard a lot about healthcare access. I think we all know that there's a lot more to healthcare access than the number of licensed beds in hospitals. It also has to do with the availability of physicians and other health care professionals, access to transportation and the price of prescription drugs just to name a few. There are many facets of health care access that aren't under the purview of CON, although we think the CON Commission has done a good job of promoting health care access to those areas that are covered under CON. Note that the proposed standards show a statewide need for beds that is 15 percent higher than what's in the current standards. As you discussed at your December 9th meeting, there are additional

hospital bed standard issues that warrant further review by the Commission just such as criteria for establishing new hospitals. A charge relating to these issues is next up on your agenda. Beaumont supports moving forward to address these issues, but they are separate from what you're being asked to vote on today. These issues would be taken off after passage of the proposed hospital bed standards before which again we urge you to take final action. In the past, one of the criticisms of the CON process was that it is slow and unresponsive. In the last couple of years the CON Commission has become much more responsive and should be commended for that. You passed these proposed standards for public comment on December 9th, and today there have been no convincing arguments put forward as to why final action should not be taken. To delay final action on the standards without do cause would represent a step backwards. Thank you for the opportunity to provide comments.

CHAIRPERSON TURNER-BAILEY: Thank you. Are there any questions? Larry Horowitz.

MR. HOROWITZ: I'm Larry Horowitz of the Economic Alliance. I appreciate Dr. Sandler's reference to our and adjoined with him and others and work out a common consensus approach on CT which was acted on but also MRI (inaudible) in that I come before. In that same vain I come before you to say we're delighted to support the department's three-part compromised proposal in terms of dealing with this very (inaudible) this amazing set of different issues. We certainly would agree, the people who've spoken so far about the value to be taken final action today to approve the bed need standards as presented before you that includes the subarea configuration. It's clearly a significant improvement over what we now have. It would mean that we would have the first time the update in the subarea configurations in 30 years. Actually, that's long overdue. It would make significant improvements in the bed need criteria and should completely as MR. Steiger mentioned to the underlying premise that a used bed is a needed bed, and has dropped the last remaining portion of the normative of saying, you know, you can't go beyond the statewide average. It will take into account (inaudible) degradation of the population and rural considerations and distinction of pediatric beds and OB-GYN factors. Other things made (inaudible) Dr. Griffith's comments were all taken care of. That certainly doesn't mean that we are not supportive of the second leg on the department's three-legged stool of asking the Commission to go forward. And now dealing with the access issue (inaudible) support the notion in terms of the statutory deadline of dealing with Section 2215.10, I think that's a very useful way of proceeding. If you look at the statutory provision you can make a change that this Commission was supposed to have acted on this by February, six months after Mr. Cory was confirmed. So that's the only thing that makes sense to have that be the first priority. But that language is to so general I know of no concern about hospital beds, new hospital exemptions for somebody who wants to do something outside the bed need standards or conformity (inaudible) you can have every one of those issues under those that 1.0 language. I think it's a very appropriate since that it's a six month deadline may be sooner. We're going to just mention that this access issue is a simple one. The ad hoc didn't attempt to deal with it. I think it needs for the department and anyone else who has a view of what access means to come very promptly before you, come very promptly to the committee and define what that means and define what that means and how to operationalize it. Just let me give you an example. Does access mean the number of miles as the crow flies, as MapQuest would tell you it is? It is the number of drive time minutes? Do you take into account the difference between whether or not people have cars in the area? Clearly, if it's X number of driving miles but if there's low automobile usage in a given area as there are in many central cities as the group that spoke before you February 26th mentioned, if you want to take that into account. You're still going to have differential considerations in the U.P. versus subgroups versus central cities. This is a very complex issue to come with a consistent, you know, basis for. So it's not for any accident that people haven't figured out how to do that. I know of no place in America that has operationalized. This would be cutting new ground. So that's a very appropriate thing to do and we just want to be strong and supportive of it. I look forward to participating in this effort. Third, the next thing coming to you is you're going to need to create a review criteria. If is this system ever develops a need for beds, (inaudible) no room for beds in any of the subareas you're going to have to figure out how -- if there is 300 beds needed in someplace or one hospital needed in some geographic area, how you decide who needs it. I guarantee you that there are more beds available in growth areas or more hospitals needed in growth areas you're going to have more applicants than (inaudible). And under Supreme Court document you're going to have to figure out some the comparative view criteria. We don't have any comparative view criteria in the hospital bed standards. Then the third item the department school is of course the negative employment (inaudible) team makes sense to proceed expeditiously (inaudible) this will be a hotly pursued group. I would comment about the department's draft language is just to remind people that when you appointed this

new standing advisory committee you have a heck of an obligation. You have to have two-thirds of them be experts, you have to have representatives, s provider organizations, consumer organizations, pay organization and purchase organizations (inaudible) and they will hopefully be called experts. But it's not a very simple task to create a standing advisory committee, it's more difficult to fashion in all those constraints than even the criteria for ad hoc. So again in summation, I urge you to take action on this so that we have bed need standards in subarea configurations are up to date to reflect population shifts, to reflect usage changes while you pursue the best. And I apologize for this, we wouldn't want to make the best be the enemy of the better. Thank you.

CHAIRPERSON TURNER-BAILEY: Any questions? (No response). Stephen Scapelliti. One small break.

(Off the record at 10:30 a.m.)

(On the record at 10:31 a.m.)

CHAIRPERSON TURNER-BAILEY: Okay. We're ready.

MR. SCAPELITTI: Good morning, I'm Stephen Scapelitti, Counsel for Unity Health, LLC. I appreciate the opportunity to be able to speak to you this morning. As you may recall, Unity Health was before this commission on February 26th of this year at I special hearing. And at that time we made a presentation concerning an unmet need on the eastside of Detroit. At the time of that hearing there was discussion about the possibility that some methodology before this Commission today may help to address some of that. I am here today to tell you that Unity Health has found nothing in this methodology that will help address the critical health crisis on the eastside of Detroit and throughout much of Detroit, although we do find some of the proposed standards, some of the proposed bed standards, to be a welcome change. There are deficiencies that will not in fact address this problem. In the last five years five hospitals have closed in the City of Detroit on the eastside alone. That's a total of 1,700 beds that have come off-line. Those beds were transferred to other facilities as they are permitted to do so under the existing laws. Yet, those beds, while still in the inventories of Detroit hospitals are not in fact available to the general public. The methodology that are included in these new bed standards simply maintain the status quo. They don't in fact address the availability of beds. If we're looking at access we must be asking what is the real access, not just a question of drive time but a question of access to the beds at the time that the patient gets to the hospital. A 12- to 15- hour wait that people report in emergency rooms in the City of Detroit due to the unavailability of beds should be unacceptable to any medical practitioner. It should be unacceptable to our community. We proposed a project, and I'm not here today just to push the project but to say our project has been proposed to address the critical health care shortage on the eastside of the Detroit, only with respect to the eastside of Detroit. There are shortages throughout the city of Detroit. Under these new standards we will show that Detroit itself under the new subarea 1b is under-bedded by 1,700 beds. And again that is clearly inventory, that does not look at the real access to beds. Now, we welcome the idea of Detroit being looked at as its own subarea, it's realistic really and it does look at Detroit then as its own entity. As we've indicated during our February 26th presentation, the people on the eastside of Detroit have a great deal of difficulty getting transportation to hospitals. It's not enough to say that Detroit is part of the sub areas that include the underlying suburbs and the people can always get to some of those facilities for health care, many of them cannot. But this new subarea alone does not address the following problem. And the methodology that is before you will not in fact address the shortage. And there's still need on that side that the Unity proposal will have to be addressed, or some other project will have to be put in place to address that shortage. Now, we do applaud the new requirement in Section 9 (1)(2)(4) that an applicant must participate in Medicaid in the first two years of application. It's right, it's proper. It does address the question of access to health care not only in the city of Detroit but throughout the state. However, Section 16, the new proposed Section 16 requires proof of Medicaid participation by an applicant at the time that the applicant files an application for the hospital beds. Now, form CMS 855A is the application form that must be filled out to participate in Medicaid. It can only be filled out by a provider. A provider is defined in that form as a hospital, critical access hospital, skilled nursing facility, nursing facility comprehensive tiff outpatient rehabilitation facility, home health agency or hospice that has (inaudible) participate in Medicare. That provision alone would restrict access to hospital beds --I'm sorry would restrict any new projects to existing hospitals in Michigan. A group looking to start a new hospital would not in fact be able to make an application for beds in the state

simply because of this Section 16 requiring that they be a Medicaid provider. They can't be a Medicaid provider if they're not already a hospital providing access for Medicaid patients under the statute. So this would in fact restrict the ability of applicants to those existing facilities, it closes the market for new hospital activities and new hospital entities. And I submit that in all likelihood has possible federal and state antitrust implications as well. We realize that this Commission struggles with this concept on a regular basis. I think there will never be in any final resolution of the issue of bed methodology. But at least from the standpoint of the eastside of Detroit, we ask that you reconsider this methodology, you reconsider the standards and help us to an address the critical need on the eastside of Detroit and throughout Detroit. Thank you.

CHAIRPERSON TURNER-BAILEY: Thank you. Are there any questions. Commissioner Goldman.

COMMISSIONER GOLDMAN: Yeah, let me understand your last point. If I understand you correctly you're saying that there's a Catch 22 in the language that we put in that we are required to put in by the state legislature about Medicaid and Medicare participation. So what would your solution be that would allow us to be in compliance with state law and also a new in the facility to exist in Michigan? If I understand you correctly you're saying if a new facility can't exist because in order to exist they would already have to prove that they were participating (inaudible).

MR. SCAPELITTI: There's a problem under this draft language an application is not even considered complete unless the applicant proofs that the applicant is already a Medicaid provider. And quite frankly I'm not sure what to suggest that except that perhaps you could still look at the application, you could still consider the application and grant a conditional approval pending the applicant showing them upon being granted hospital beds that the applicant would qualify to provide Medicaid --I'm sorry -- to participate in Medicaid.

COMMISSIONER GOLDMAN: So either you would be a provider or you would certify to the Certificate of Need Commission that you will in fact if you are granted beds apply for, obtain and participate in the federal program.

MR. SCAPELITTI: Yes. As I said, under Section 9, the new language in Section 9 does cover that. And we applaud that, we think that's a fantastic provision.

COMMISSIONER GOLDMAN: So what if 16 says an applicant shall provide verification of Medicare participation or application for Medicare -- Medicaid rather -- participation and –

MR. SCAPELITTI: Well, again, you can't apply until you are in fact a hospital. But you can make application for Medicaid upon becoming a hospital, so if you wanted to require that within a certain amount of time after becoming a hospital facility, and again I don't mean to substitute myself for the attorney general's office, but my opinion that would be satisfactory.

CHAIRPERSON TURNER-BAILEY: Are there any other questions or comments.

MR. HORVATH: Commissioner Goldman, I'd just make clarification, this is the point that we brought up earlier in the day that the way the department will operationalize this is that at the time of application for brand new providers who don't have a Certificate of Need to become a facility yet that they will have certain things that they will have to stipulate state in their application that they will submit to a Medicare certification, they will submit the proper license and requirement. And upon that submission and their application the department will make a stipulation granting their CON that prior to start of operation you must then come back to the department with actual approve of Medicaid participation. So we do recognize that this is a problem for new applicants and it will be dealt with in that manner. For those that are established entities in the state already, they will have to demonstrate at the time of application actual participation in Medicaid.

COMMISSIONER GOLDMAN: So the department would look at Section 16 and interpret verification of Medicaid participation to mean upon receipt of beds they will properly apply for and participate in Medicaid, obtain certification and prior to initiation of services demonstrate Medicaid participation?

MR. HORVATH: Correct, meaning that at the end before they start operation they have to come back with a letter from the Medicaid Department saying that they are now an enrolled Provider.

MR. SCAPELITTI: And again just my recommendation would be that that long language actually be incorporated into the standards, otherwise the standards have a chilling effect on anyone looking at that and saying 'I can't even bother applying because if I look at the standards the way they're written I know that I cannot satisfy them.

CHAIRPERSON TURNER-BAILEY: I think I for one am satisfied with the department's discussion as to how they would operationalize that, but that's my personal comment.

MR. HORVATH: Once this passed this will be a public advisors notice put on the department web site about the process for this about submission of documentation prior to the application.

CHAIRPERSON TURNER-BAILEY: Okay. Thank you. Are there any other questions or comments for this speaker?

(No response). Thank you.

MR. SCAPELITTI: Thank you.

CHAIRPERSON TURNER-BAILEY: Cheryl Miller.

MS. MILLER: Good morning. My name Cheryl Miller, and I'm Senior Manager in Trinity Health Corporate Strategic Planning Office. I'd first like to start off by thanking the Commission and the Department for allowing me to serve on both the Hospital Bed Ad Hoc Committee as well as the Technical Advisory Committee. It was a privilege to be a part of both groups and to work closely with key MDCH staff members as well as colleagues around the state. These groups worked very diligently and I'm very proud of the work product that was the result. In fact, it reminds me of a paper I did in grad school " Certificate of Need: Curse or a Necessity". And to tell you the truth we did work but we had a lot of fun doing it. And my thanks to all that worked on that group. Like several of the speakers before me, I urge the Commission to take final action today to adopt the proposed bed standards. The revised subareas and bed need methodology have been discussed in great length at previous meetings and public hearings, and I'm not going to re-address all of the specific changes. However, as Patrick and Dale mentioned, I think it's important to note that the proposed bed need methodology will actually increase the statewide bed need by almost 15 percent. Are the revised subareas and bed need methodology perfect? Of course not. However, the proposed changed incorporate badly needed revisions that are imperative to be consistent with licensure. Actual hospital use rate data were used as opposed to statewide averages that negate health status differences among communities. Target occupancy rates were liberalized to reflect variability in actual demand at the subarea level. While the entire state remains over-bedded, the increase in bed need clearly that the revised methodology is highlights reflective of the actual demand for inpatient capacity. Today, the Commission will be reviewing a charge for a new Standard Advisory Committee that will involve further evaluation and possible further revision of the bed standards. It would ideal to have this new group base its work on updated subareas and updated bed need methodology as opposed to subareas that were in place since the 1970s. Again, I'd like to thank you for the opportunity to serve on the Bed Need Ad Hoc and the TAC. And I urge you to adopt the proposed bed standards. Thank you.

CHAIRPERSON TURNER-BAILEY: Are there any questions? (No response). Thank you. Vin Sahney.

MR. SAHNEY: Good morning, my name is Vin Sahney, and I'm Senior Vice President of Henry Ford Health Systems. I'd like to make five points about the proposed bed need methodology. And I'd like to focus on one specific issue and that has to do with the subarea. In fact, to begin with I would agree with both Cheryl Miller and Patrick O' Donovan, and he probably thought I would never stand here and agree with our friends from Beaumont and Trinity. And they worked very hard and they worked long hours. We

had some testimony from Professor Griffith who was (inaudible) in a minute. But I think what happened is since they started the subarea location with the wrong assumption. They ended up with conclusions that don't meet the simple common sense test. I'll give you examples of that in a minute. So my argument is not-- if it mean well, no problem; if it work well, no problem. Did they bring if experts? Yes, but they decided to listen to what they wanted to listen to. And an example of that is the letter of Professor Griffith who is the originator of the methodology. And I read you his conclusions. I can no longer support the bed need methodology as being the best interest of the people of Michigan. I mean, I got the same letter and I read his conclusions and he says "I cannot support this methodology". And so what's the problem with the methodology? That's the question we never ask. We don't take the formula. So let's suppose I apply this formula that Professor Griffith developed that idea. I was part of his team when they developed it. Well, what's the problem? The problem is it basically signs affinities to where people are currently going. So if I apply this methodology to gas stations and the population had expanded 15 miles further, and I say 'Yeah, but hold on a second. People are already getting gas from the station 15 miles from wherever it is. Why do we need to assign a new gas station in the new area'? This is the problem with the methodology. The question of methodology is biased because it uses 1978 hospital supply and configuration. It uses the analysis from that fixed basis. If you look at the sub area, the new sub areas that have been defined using the methodology you will find in some subareas, even in the open populations there are only 100,000 people. In other subarea there are 1.5 million people. And we have to stand back and say 'Hold on a second. How did you end up with a subarea with 1.5 million people'? Why not divide it into three subareas of 500,000 people? Why did you allocate the new methodology of a subarea with only a 100,000 people? What methodology is used? Why didn't you group up it, combine it with the next adjacent subareas? None of those questions have been answered. Instead, we are hiding behind a formula that most of the people can't understand and you say 'Well, that's what the computer ran and gave it to us'. And that's why we have to apply some common sense methodology. And I would challenge you to ask those kinds of questions. And if you need to invite Professor Griffith up here and ask him point blank does this methodology work? What happens when the population expands? How would it allocate the numbers from the new geographical area that's adjacent to the current hospitals. And I think this is -- to me this is departmental flaw in this methodology. Another point I'll make is that the technical advisory committee in its own report when they presented said that they asked other states. And they asked them what kind of methodology for inpatient beds was being used by other states. No other state is using this methodology. It must be some reason. They identified that most other states that will that have CON were using either county boundaries or population (inaudible).(Inaudible) let's divide it up in some reasonable population so that there are some equal sizes there. So I believe that this is a simpler more realistic tick methodology. It's understandable by most people. An example would be to take subareas in Oakland County that are implement of 500,000. In rural county you could use county boundaries or use distance or time access as Mr. Horowitz had also mentioned. I think that would be at least you could stand up in front of public and say 30 minutes is a standard or a county boundary is a standard. So the bed need methodology that has been presented to you is predicated on maintaining the status quo and does not so adequately serve the future population of the (inaudible) in Michigan. So I would suggest that it needs more work. I think since it is a recommendation by the department to maybe to look at access. I think the specific issue of subarea location should really issue re-looked at. I do not have a problem with the other parts of the methodology which using normative methods and others, there is no problem with that.

CHAIRPERSON TURNER-BAILEY: Thank you. Are there any questions?

COMMISSIONER SANDLER: Specifically Dr. Season what is your recommendation?

MR. SAHNEY: My recommendation is that this be sent back to the Committee and they should come back with the methodology or adjusted for populations or subareas that are defined, have some meaningful size of those. So right now as I gave examples of the some subareas within metropolitan reas just have two hospitals, other have 11 in it, and the population that is five- six times of that. I think some national method of that should come back so the subarea of the methodology needs some work.

COMMISSIONER SANDLER: Thank you.

CHAIRPERSON TURNER-BAILEY: Are there any other questions. (No response). Thank you. Dr. Lonnie Joe, Jr.

DR. JOE: Thank you, Ma'am and the Commissioners. Thank you for this opportunity. My name is Lonnie Joe, I'm a practicing physician in the Detroit, president of Unity Health. However, today I stand as a physician taking care of the citizens of the State of Michigan in particularly the citizens in the metropolitan Detroit area. I stand in opposition to the Committee's report in terms of bed utilization as it relates to proportionate, zones, subarea, etcetera. I think it is time we come to the realistic understanding of what needs are really and what matters in terms of what's needed around this state. If my 17-year-old son comes home after getting allowance on Friday and he comes in on Monday and wants more money, I want to know what happened to the money that I gave him on Friday. As a matter of fact, it's about accountability after a point. We suffer through lots of catch phrases in health care now in terms of where we would like to land in terms of what we say. One of them is basically being responsible for what we do with the health care dollars. This in turn interprets what we do with health care anything, including beds. We have to look at outcomes. We suffer from the lack of understanding outcome based medicine and now we're suffering from the lack of understanding of how outcomes actually come about in terms of what we've used in terms of the law. We have bad laws in this country. As most people would agree, we also have bad approaches to resolving bad laws. And I think we have to begin to look at where beds are, where the people are and what the true needs are. We can't run and we can't hide from this issue. Therefore, in defense of

patients, we ask that you vote against these standards. Thank you.

CHAIRPERSON TURNER-BAILEY: Are there any questions? Commissioner Goldman.

COMMISSIONER GOLDMAN: DR. JOE, the position that you've just taken is certainly consistent with what we've heard with your testimony at the last meeting with respect to creating a new hospital for the eastern part of Detroit. But for that would you have made these comments today?

DR. JOE: We've made these comments before. Not necessarily in the presence of this Commission. We've been making maybe these comments for years around the City of Detroit. However, they've fallen on deaf ears simply because we think the people have good intentions when it comes to attempting to solve these problems. But there are so many special interest groups and special agendas that have to be met, the bottom line, the outcome it that patients suffer. So here again years later we're still making these comments just in a slightly different arena.

COMMISSIONER GOLDMAN: Well, beds have been available in Detroit for years. Beds were available, hospitals were available. Many of those hospitals that you've pointed out to us have left the city. So explain to me how your comments effect this methodology.

DR. JOE: The bottom line is that from as I see it the proportion of beds in Detroit still is just a number and not just necessarily actual use of beds. I think that somewhere along the line we've got to be realistic about how you use beds and not just give beds. There has to be a realization of what happened to the beds at some point in time down the calendar. If my 17-year-old son gets an allowance on Friday I want to know what happened on Monday when he comes back asking for more money.

COMMISSIONER GOLDMAN: With all due respect, that is a separable question that we can take up with a new committee. What this methodology is what's allocated as. What you're saying is Step 1 may be allocation of beds, Step 2 out to be an ongoing inventory to see if the allocated beds are actually in use and if they are in use for appropriate purposes. I'm just trying to understand your position.

DR. JOE: Sure.

COMMISSIONER GOLDMAN: Because I think that may be a separable question that would be very important to address, but first you establish the floor of what beds are needed in what areas. And that's what Dr. Sahney was trying to address. And then you say 'okay, if those beds are needed in certain areas let's see if they are being used in a way that provides appropriate access to appropriate services for the citizen'. I mean, one of the issues that the Certificate of Need always has to address is this question of demonstrate need and demonstrate appropriate access. This is the need question that we're trying to get our arms around. And then there may be, as you suggest, a separable question that we ought to pass

a committee to look at in terms of having to demonstrate what the floor is is access appropriately being handled, is the inventory being appropriately handled.

DR. JOE: Yes, I think you're exactly right. I agree with you 100 percent. I think though to challenge one or to attack one without addressing the other means that your ability to windup with an answer is further up down the road. I think you can fast forward this by combining the two together and talk about how you actually achieve the outcomes that you want. Remember, these decisions that you make interpret into dollars that are spent in health care. And we all are concerned about that. I think that the systems have expressed more so than anyone. We're all concerned about that but it's very hard to work around law that handcuffs you on one hand and slows you down on the other and remain legal, you know what I mean, okay. So here again I think that just to address one end of this is putting oar in the water and wondering why you can't get off in the right direction. Thank you.

CHAIRPERSON TURNER-BAILEY: Thank you. Any further questions? (No response). All right. That's the end of the public comments on this issue. At this time, are there any discussions among the Commission or a motion relative to this language?

COMMISSIONER SANDLER: Yes, I have a motion then we can have discussion following the motion that the --

COMMISSIONER DEREMO: This is Commissioner Deremo. Am I being heard?

CHAIRPERSON TURNER-BAILEY: Yes.

COMMISSIONER DEREMO: I apologize. I did have question for the Department staff just for my own clarification, and this is more of a technical question. On page 2 section 2(1)(h)1. As I understand it says that this discharge relevance factor means a mathematical computation where the numerator is the inpatient hospital discharges from a specific zip code for a specific hospital subarea and the denominator is the inpatient hospital discharge for any hospitals from that same specific zip code. If I understand the formula that means that then there is a bias to hospitals that already exist in a service area related to figuring out bed need methodology. Is my understanding correct? (No response). Mathematically I'm just trying to understand. There seems that there is a bias built into the currently methodology.

MR. NASH: This is Stan Nash. And in Section 3 it defines how an applicant is to do a statistically valid market survey. And the basic principle that was tried to be addressed in Section 3 was 'how do you rob Peter to pay Paul'? And that is if you're adding a new facility you have a fixed number of discharges for a given subarea, and how do you redistribute those to a new facility. And the market survey that is identified in that section allows the applicant to go out and essentially prove that they are able to support the redistribution of patients to the proposed new facility. And so while the language there may look a little complicated I think I've given a Reader's Digest condensed version.

COMMISSIONER DEREMO: I understand what you said. My second question, Madame Chair, is that with the Department Staff raised the issue that the bed need methodology is acted independently the action of an advisory committee that would look at the issues of access of care would be a concern to the department. Is there any --is there a reason why we are acting on this first rather than acting on the advisory committee? Because for me personally, I would feel more comfortable in looking or acting on the bed need methodology if I knew that we were going to be moving forward with an Advisory Committee. I don't know if other commissioners have that same concern or if I am independent.

COMMISSIONER HAGENOW: That is correct. What the question I had too in terms of the order, and maybe it's from being not physically present, I think it seemed like there's nothing that we probably are going to vote on in this short-term that is of the kind of moment that the bed need methodology is all about. And then to have a motion around access of application of it in some way coming second doesn't seem in the right order.

COMMISSIONER SANDLER: Perhaps I can -- I'd like to make a motion that the current methodology that's been proposed be reviewed and be added upon to include population in the subareas which appears to be the problem or the concern that's been expressed.

COMMISSIONER BREON: Could you restate that for me?

COMMISSIONER SANDLER: That the current bed methodology committee, that we not adopt the current bed methodology committee until the Ad Hoc Committee or the successor committee has the opportunity to look at the population in subareas, which appears to be the concern of the people that's been expressed, and I believe a concern of the commissioners on the phone, if I understood Commissioner Hagenow correctly. Is that -- did I understand you correctly Commissioner Hagenow?

COMMISSIONER HAGENOW: Yes.

COMMISSIONER SANDLER: Okay, thank you. That is a motion actually.

CHAIRPERSON TURNER-BAILEY: There's a motion on the floor, is there support? (No response). Hearing no lack of support the motion dies.

COMMISSIONER MAITLAND: I move that we approve the Hospital Beds Subarea and Bed Need Methodology.

COMMISSIONER DELANEY: Support.

CHAIRPERSON TURNER-BAILEY: It's been moved by Commissioner Maitland; supported by Commissioner Delaney that we approve the hospital bed needs ad hoc advisory support language. Any discussions?

COMMISSIONER DEREMO: Yes. Is this a separate freestanding independent issue compared to the standard Advisory Committee looking at the issues of access?

CHAIRPERSON TURNER-BAILEY: Yes, the discussion of the charge for a standard advisory committee is the next issue on the agenda. It's not wrapped up in this particular issue but it is the very next item on the agenda.

COMMISSIONER BREON: I certainly support approving something but I also I think we ought to have that advisory counsel first, so that's a secondary issue. So I guess for those who are concerned that we'll vote on one and not vote on the other I guess I'd just like to preview me vote which is I would support both of those.

CHAIRPERSON TURNER-BAILEY: And I think we're hearing that on the phone as well that there is a strong support for doing something important with the next agenda item.

COMMISSIONER MAITLAND: I'm not opposed to setting up another advisory committee, but I don't think it's appropriate to have it as a part of the adoption of the set of standards that we (inaudible).

COMMISSIONER SANDLER: I think I concur with that those two issues. I think the motion stands alone. And if someone wishes to make a motion after this is voted upon that is a separate issue.

CHAIRPERSON TURNER-BAILEY: And it is the next agenda item. Commissioner Goldman.

COMMISSIONER GOLDMAN: As I understand it, the motion that was made is to approve the standards. And I take it that that motion incorporates the Department's statement that they would interpret Section 16 for new facilities in the matter that they discussed and make that interpretation publicly available. With that understanding I would also be supportive of this motion and of a separate motion for the next item to look seriously at the access issues.

MS. ROGERS: And again these standards also reference the Department of Consumer and Industry Services so if we also add that as an amendment to change those instances to the Michigan Department of Community Health.

CHAIRPERSON TURNER-BAILEY: Commissioner Maitland, do you accept that?

COMMISSIONER MAITLAND: I have no problem.

CHAIRPERSON TURNER-BAILEY: Okay. It's been moved and supported that we take final action on the Hospital Bed Ad Hoc advisory Committee language, that we approve that language with certain minor changes and that have been suggested. Any further discussion? (No response). All those in favor please signify by raising your right hand. Okay. Six here. And on the phone --seven here. And on the phone. Okay. And two more so that makes nine and one nay -- and two nays. Thank you. The motion carries.

MR. STYKA: Are you going to be moving to wave on the 135-day provision of the bylaws?

MS. ROGERS: Because this Ad Hoc committee (inaudible).

CHAIRPERSON TURNER-BAILEY: Okay. Should we have done that with the motion?

MR. STYKA: Do a separate motion.

CHAIRPERSON TURNER-BAILEY: Okay. So can we have a motion to waive the --

MR. STYKA: Article 5(c).

CHAIRPERSON TURNER-BAILEY: Article 5(c) 135 day-- we're waiving --

COMMISSIONER SANDLER: Please explain that.

MR. STYKA: Article 5(c) of the bylaws says that the Commission shall submit final actions to the in the Governor in the standing committees pursuant to Subsection B, etcetera, no sooner than 135 days after the first meeting of the add hoc convenes of said Article 6 unless the Commission approves by a majority vote to suspend any subsection (inaudible). Well, actually it's probably well beyond that but as a matter of routine we usually, but I guess you don't need to.

CHAIRPERSON TURNER-BAILEY: Never mind?

MR. STYKA: This Add Hoc has been around for a long time. I don't think I was here when they started so forget it.

CHAIRPERSON TURNER-BAILEY: Okay. Great. The next agenda item: Hospital Beds- Charge for a Standard Advisory Committee. And there's been a lot of discussion on this piece already, and I think I would like to ask the Department to just run us through your recommendations for the charge of the committee here. Mr. Christensen.

MR. CHRISTENSEN: Thank you very much. We have, I think distributed the charge to all of the commissioners. And basically it would create a standard advisory committee, unlimited, with a requirement to report within six months, not more than six months. So if it came to conclusion quicker, the reports, findings quicker. Recommendations were related to the fulfillment of Section 222.1(o). The language and code that we were required in 619 that we were required to address and to include information or recommendations and modifications of standards to insure the appropriate accessibility to health care. So this is the access issue that the Department has been did and remains very much concerned about. And what this standard advisory committee will get to do would be to drilled in on that, focus in on it as previous speakers and public comment have made. It's not an easy thing to do and it may not have been within the direct charge of the original committee that created the standards that you just adopted. We would recommend that we get a -- the second language there -- that the process for selecting the committee we solicit from individuals who are interested in and commission members who are interested, and meet the requirements in 619 to meet the right representation of the various individuals and groups that need to be represent on that committee. And that the Commission come back end of April and figure its process for selection of the applicant. If you only have 10 applicants or 15

applicants you have all of them, but if you get 1,000 applicants you may want to figure some process for bedding that with the Commission. We consider this an essential motion as a part of overall support for the standards you just passed.

COMMISSIONER CORY: I propose a motion by the (inaudible).

CHAIRPERSON TURNER-BAILEY: You propose pieces of that as a motion. Any questions?

COMMISSIONER SANDLER: I would second the motion.

COMMISSIONER BREON: I have a question. Does that -- Jim, do you only look at that area that is stated on this (inaudible)? Or does it open up everything for discussion.

MR. CHRISTENSEN: Well, it would be limited to the rational interpretation of what's here. And to that extent I mean there is a sentence there that says modification or development to standards that shall be to insure appropriate accessibility to health care. That's major issue that's being looked at there consistent with the charge, which I think it is included in the charge it's in a little subsection that's in 619.

COMMISSIONER DEREMO: Could somebody, because we're on the phone, restate the motion so that we hear it specifically?

CHAIRPERSON TURNER-BAILEY: Would you restate your motion Commissioner Cory.

COMMISSIONER CORY: I move that we accept the recommendations as presented by Mr. Christensen.

COMMISSIONER DEREMO: Thank you.

CHAIRPERSON TURNER-BAILEY: Your second piece of the motion, now this is a question that I have, it looks like you're suggesting -- in the history of the Commission what we've done in electing add hoc advisory committees is to have the Commission basically to allow the chair to work with the Department in looking at applicants and making a recommendation to the Commission relative to the makeup of those Commissions. And I'm reading this to mean you think that we should have a change in that approach?

MR. STYKA: Currently the bylaws say that the chairperson appoints the members of the advisory committees. The current bylaws refer to ad hoc but I think we can reasonable read that to mean advisory.

CHAIRPERSON TURNER-BAILEY: Okay.

MR. STYKA: Until you get around to changing it.

CHAIRPERSON TURNER-BAILEY: Which we are going to work on but it hasn't happened yet, correct?

MR. CHRISTENSEN: We're not specifically recommending any change to the procedure, but we think it's important since we have potentially three additional commission appointees which will be present at the May 11th meeting that we have an opportunity for the Commission to consider how it wants to handle that. If you have 1,000 applicants respectfully submit the chair may need some additional subcommittee to get somethings through or whatever. But we leave that to your deliberations on the May 11th and see what we get in response to that.

CHAIRPERSON TURNER-BAILEY: Okay.

COMMISSIONER MAITLAND: Jan's certainly optimistic that we're going to have a 1,000 applicants, I don't think we ever had have. This must be an exciting new topic. But I don't think it's that (inaudible). I don't disagree with it. We've always (inaudible) the chair. Occasionally we brought it to the full Commission and discussed it. It never was a problem. Usually it was recommendations of the Department, but I guess now that I look at it I don't think that that second to last paragraph, while I don't have any problem with it, I don't think it should be part of the charge. I just soon adopt the charge without

that. That's really a technical way of how we're going to proceed and I don't have any problem with it. But we've never put that type of thing in a charge before so I don't know how everybody else feels. But I don't have a problem with it but I think that we should adopt this charge without that paragraph in it. So I will go against it under that motion. It's not a big huge thing but --

COMMISSIONER SANDLER: Are you making that an amendment, are you amending the motion, Mr. Maitland so we can vote on that?

CHAIRPERSON TURNER-BAILEY: You're talking can about the Step 2 piece?

COMMISSIONER MAITLAND: Well, I could say that we amend to charge to remove paragraph a--

COMMISSIONER SANDLER: Well, you would have to make it as a motion because --

COMMISSIONER MAITLAND: That's true. I move that remove paragraph 2 to discuss separately as part of that activity of taking care of the charge.

COMMISSIONER SANDLER: You have to decide whether that's friendly or unfriendly. If it's unfriendly that would be a separate vote on it.

COMMISSIONER CORY: I'm willing to vote on your amendment.

COMMISSIONER SANDLER: You consider it unfriendly.

COMMISSIONER CORY: Not in a personal sense.

CHAIRPERSON TURNER-BAILEY: Okay. Do we need a support for that? Okay. Is there a support for the amendment to the motion.

COMMISSIONER BREON: Support.

CHAIRPERSON TURNER-BAILEY: Support by Commissioner Breon. All those-- any discussion?

COMMISSIONER SANDLER: I'd just like to say that we trust Mr. Christensen, and why don't we just take it in total.

CHAIRPERSON TURNER-BAILEY: I want to listen to the public comment too. I wonder when I get to do that, anytime I want?

MR. STYKA: I think you should deal with this. Parliamentary speaking, you need to deal with this.

CHAIRPERSON TURNER-BAILEY: All those in favor -- at this point we're voting on the amendment to the motion. And the amendment would be to look a the charge to the Standard Advisory Committee on its own and separate a discussion of the process for selecting the Standard Advisory Committee. Am I stating that correctly, Commissioner Maitland?

COMMISSIONER MAITLAND: Yes.

CHAIRPERSON TURNER-BAILEY: All those this favor signify by raising your right hand. On the phone. Five voted for so therefore the motion does not carry. We're going to go back to the original motion which is to accept the Department's recommendation in total. It has been supported, there has been some discussion. And I have one card for public comment James Ball. He'd like to come up. Then I'll call for the vote at that point.

MR. BALL: Thank you. Just a couple of brief comments. I do support the idea of the charge with perhaps a couple of questions or concerns, and maybe that just gets operationalized in the process. References made in the charge to submitting the recommendations within no more than six months, and I wonder if you might want to say in six months from the first meeting of this SAC. Because you're looking at action

in March and not even discussing appointing this SAC until May. And if you interpret six months from the date of the charge you've already lost two months in that process, so you might want to consider that. Another concern I have is you heard at your February 16th meeting and this morning people from Unity talking about one of the issues is the existing capacity and the fact that unused understaffed beds and whatever tie up the ability to move things. Now, our ad hoc over the several years that we've dealt with things always tried to get into that and people would say, you know, those our property rights and you can't have the state taking the property and so forth. And I wonder if it ought to be clear in this that that should be part of what this SAC would look at is the issue of the impact of the access capacity that isn't being used and how to take it off stream. I think it might be on this point in time where people need to think outside the box and look at concepts that they may not have looked at before. You know, there's taking of property all the time by the state through eminent domain and other ways of doing things. And maybe this group needs to look at those kind of concepts. The other concern is I heard Mr. Christensen say what's to be looked at is the rational interpretation of what's here. And I'm not sure on, you know, who makes that interpretation of being inside or outside. And this is sort of starting by making it a review of the Hospital Bed Standards, you seem to be starting with a concept that the answer to access to quality health care service is the function of access to hospitals and hospital beds. You know, Dr. Sahney talked a little bit earlier about a faulty underlying assumption, and I'm wondering if it would be within the purview of this committee that's likely to be appointed to look at an issue and say that an issue that's been brought before them is not a function of access to hospital bed, it's a function of perhaps other needs. On February 26th, we heard about lack of individual transportation, lack of public transportation, lack of access to technology that is required to protect physicians from liability issues, lack of access to testing equipment because the poorest of the poor want tests they read or hear about whether they're needed or appropriate or not, physicians have to be able to address those demands. You know, those are often not issues that have anything to do with hospitals or hospital beds, so I'm wondering if when this new committee looks at promoting and insuring availability and accessibility of quality health services of reasonable costs if they're obligated to say that if they determine there is an access problem that the only way to solve that is by creating or moving hospitals and hospital beds. I indeed think that many of the issues I've heard about over the years don't have anything to do with hospitals and hospital beds at all. Thank you.

CHAIRPERSON TURNER-BAILEY: Thank you. Are there any questions. Larry Horowitz.

MR. HOROWITZ: I'd like to make an appeal. As I indicated, the Economic Alliance by not only our leadership but more importantly our full board discussed this issue on Thursday. And I discussed it subsequently the leadership and then public agreement that this kind of three-part compromise approach is certainly something we can support an interest in having finally some degree of consensus on this ever consent issue before this Commission of hospital beds, moving them, putting them in new buildings which are called "hospitals" or "non-hospitals" so we don't have to be fully fixated on this thing forever. There are other important issues. I'd like to point out and indeed a request of Dr. Sandler and Mrs. Hagenow if the other two parts of this document that these two proposed, the two legs of this two are approved, I would hope they might be billing willing to the standards as now they would have the assurance that all three things are happening. In the same way, I'd like to urge other members of the Commission that what's being presented here by the Department is that this second paragraph is not part of the charge, they separated it out from the charge. So one is called the charge, and all this business about how you go about creating a committee is not part of the charge, it's a separate item. I don't think there's any -- if someone wants to split them up, it's a matter of Robert's Rule of Order that if there're two separate items contained within a motion any member can ask for a division of the motion. So rather than have it all tied up in knots as to whether we want to vote on these together or separately, it would seem to me you can vote on it separately. I think there's no question it would all be approved. I would say to everyone I think everyone's looking can for concerns and problems, I'm just going to tell you that as I read this language that comes from the statute with or without the reference to access anything can be brought up Commissioner Breon. I can't imagine that someone doesn't have an idea about hospital beds whether it's St. John, Providence, (inaudible), Pontiac Osteopathic, Unity Health, or God knows if four other people will show up in a moment now wanting to get some second consideration. It wouldn't be able to say that what they're -- part of what they're -- dealing for is the terribly important problem of access to services in some given geographic area. I can't imagine you couldn't claim access as part of your deliberation. So again, everything can come up. And this Commission, on February the 26th, already voted to deal with the community health issue at your May 11th meeting in the context of this overall standard, at which time

you could proceed to charge this Committee or do it on your own to consider unity health as a exception, you've made other exceptions, you've done it for Metro, you've done it for high occupancy is not constrained bed need, you can do what you want to do so. I don't see that this a threat Dr. Joe and staff already objected or regarding Unity Health and Henry Ford Health System, it seems to I that it's all being dealt with here. So I would urge everybody to approve both items of this piece of paper whether in two bites of the apple, two votes or one vote. The only thing I would technically agree with Mr. Ball that I do think you need to operationalize six months, you can't count six months unless you've first started, so I would support Mr. Ball's idea. But I believe Mr. Christensen agreed to before the meeting let it be as it normally six months from the first date from the committee. That's how 135 days' counted so it seems to make sense to count this the same. That would be the only objection I would make. I would plead with everybody up there and in the audience that this is not such a problem for everybody, this will be everybody an expeditious forum to deal with all these troubles and matters. Thank you.

CHAIRPERSON TURNER-BAILEY: Okay. Thank you. Are there any questions?

COMMISSIONER MAITLAND: You know, now that I sit here and MR. Goldman pointed out that we were given this (Indicating) and I was still on this (Indicating) which has all as one so all this discussion probably, if I was smarter (Laughter) would have not have been(inaudible). So I move that we adopt the charge in the process with the one change that the six months starts --

CHAIRPERSON TURNER-BAILEY: Yeah, we have the motion on the floor.

COMMISSIONER MAITLAND: I support that then.

CHAIRPERSON TURNER-BAILEY: Okay. Great. I would like to ask Commissioner Cory if he would like to make any amendments to his motion that would address the clarification of the six-month time frame and if the Determine is okay with that?

COMMISSIONER CORY: I have no problem inserting the six-month time frame.

CHAIRPERSON TURNER-BAILEY: Mr. Styka.

MR. STYKA: What six-month time frame are you talking about, because the statute is very specific? It already has a six-month time frame from the date of appointment.

CHAIRPERSON TURNER-BAILEY: From the date of appointment?

MR. STYKA: Yes.

CHAIRPERSON TURNER-BAILEY: So it wouldn't be the first meeting, it would be whenever--

MR. STYKA: The statute takes care of the issue --

CHAIRPERSON TURNER-BAILEY: -- on the issue --okay.

MR. STYKA: From the date of appointment in the statute six months.

COMMISSIONER SANDLER: Hearing no further discussion I'd like to call for a vote, please.

CHAIRPERSON TURNER-BAILEY: Now, I was getting ready to do that. The question has been called, all those in favor of voting on the motion please raise your right hand. On the phone. Okay, there's two on the phone. There has been a motion to accept the charge for the Standard Advisory Committee as submitted as well as the process for selecting the Standard Advisory Committee. There has been a second and considerable discussion and we are ready for the vote. All those in favor please signify by raising your right hand. On the phone.

COMMISSIONER HAGENOW: Aye.

COMMISSIONER DEREMO: Aye.

CHAIRPERSON TURNER-BAILEY: Thank you. That's 10 ayes.

COMMISSIONER SANDLER: I have a point of personal privilege. I have to leave, as I told the Chair, for a few minutes, but I will see everybody after lunch.

CHAIRPERSON TURNER-BAILEY: Thank you. Next on the agenda UESWL Services. We have proposed language. I have a couple of --actually, one card Brian Reuwer.

MR. REUWER: I'm sorry. I have like to leave as well so I'd like to pass making any comment.

CHAIRPERSON TURNER-BAILEY: Okay.

MR. REUWER: Well, actually just very briefly. Some of our physicians in west Michigan have expressed some concerns about the numbers reached of the procedures and would hope that the Commission when approaching these standards keep in mind that we not set the bar too high in the number of procedures required, and that rural area are not adversely effected.

CHAIRPERSON TURNER-BAILEY: Thank you. Are there any questions? (No response). Okay. Thank you. Barbara Jackson.

MS. JACKSON: Good morning. I'm Barbara Winston Jackson, Regulatory Director for the Economic Alliance for Michigan. I'm here to support-- to testify in support of these proposed lithotripsy standards. These new standards will facilitate access to lithotripsy services by removal of the previous cap on the units as well as the enhanced leading factor which will facilitate access to a variety of providers, particularly those in rural areas. In addition, based on actual and/or projected utilization volumes, if there's a need to do so these new standards allow current providers to expand their service as well as allow new entrants into the market. We want to commend the many people who worked so diligently to address this issue, including Commissioner Dr. Sandler, who of course left he'll rejoin us later, the Departmental staff and providers. Thank you.

CHAIRPERSON TURNER-BAILEY: Thank you. Are there any questions? (No response). Donald Pietruk.

MR. PIETRUK: Hello, my name is Donald Pietruk. I'm representative of United Medical Systems on this issue. We also wish to urge the Commission, we fully support the standard that the Board of Commission in its current forum. Also, we wish to, I think, again -- I think in particular compliment Stan Nash and the Department since after the last public hearing a lot of concern was raised about access issues. And the Department looked at the formula at which the UESWL methodology was calculated and has, I think, refined it to the point where it actually has increased the amount of available data that applicants can used in the application process. So that coupled with, I think, looking at comparative review and allowing the current applicant to expand their service to the previous standard did not, I think posed away towards addressing the access on this standard. The methodology probably still needs to be looked at further given our experience and, you know, with the real world. But that's an issue that I think needs a lot more time than and a lot more work than we're able to do now. And, you know, we would be ready to work with whomever wants to work with us in the process of revising that methodology. Basically what we're still doing even with the adjustments, we're still using inpatient data to calculate a total outpatient procedure which really doesn't don't make sense ultimately. But we would urge the Commission to pass this standard, it will significantly improve over what's currently in the in the field. And we'll work further with whoever wants to work with us on this issue.

CHAIRPERSON TURNER-BAILEY: Thank you. Any questions? (No response). Okay. Is there any discussion or is there a motion?

COMMISSIONER GOLDMAN: I move to approve the standards with the amendments including the amendment that we received today to Appendix A our last speaker just talked about that, and that has to do with the factor of calculating the projected UESWL procedures under sub 1. The factor used to

calculate would be at point.98 factor, and that's the green tab that we received in the materials today. That's the only change is a technical change to the calculation. Otherwise, I think as technology changes we may have to revisit these standards in the future and look at, as our last speaker mentioned, the calculations based on other patient data that the calculations in the standards will provide additional access and access as people can hear from the testimony. You can see from the witness testimony from our public hearings was the main concern that was raised, so my motion would be to support the standards as they exist with the addition of the corrected factoring of the (inaudible).

COMMISSIONER CORY: Support.

CHAIRPERSON TURNER-BAILEY: Supported by Commissioner Cory. Any discussion? (No response). All those in favor signify by raising your right hand. On the phone.

COMMISSIONER HAGENOW: Aye.

COMMISSIONER DEREMO: Aye.

CHAIRPERSON TURNER-BAILEY: Thank you. Motion carries. At this point we are going to take a lunch break. We are going to reconvene at 12:30, and we will address the MRI issue which since Dr. Sandler is not here I want to do that first right after lunch immediately, quickly.

(At 11:39 a.m., meeting recessed for lunch) (At 12:36 p.m., meeting reconvened).

CHAIRPERSON TURNER-BAILEY:. As we're being seated, I just would like to remind everyone that we're not dealing with the best sound system here. People who are sitting in the back have mentioned to me that they can't hear. So even if you are speaking into the microphone please try to project as much as possible. The next item on the agenda -- we're back to order -- is Magnetic Resonance Imaging. I'd like to ask Dr. Michael Sandler, Commission Liaison, to give us his comments, please.

COMMISSIONER SANDLER: Thank you very much, Madame Chair. I apologize for leaving briefly, but I needed to testify before I left. I did a speed lunch to get back. This is a mild change in the MRI standard for rural hospitals that have between 4,000 and 6,000 units --not units, it would be procedures. There was a work group with Amy Barkholz of MHA, and we thank you for bringing us together, which took place on February 4th. Seven represented MSMS, MHA and the Economic Alliance, and we on reached a consensus as to what we felt the best for patient care. Basically it allows those seven or eight hospitals, well, there were seven, we understand there's an eighth one now to get a fixed MRI rather than a mobile. And the rational for this, in my opinion, is really a patient care issue. They have it four or five days a week. And they really have a difficult problem, they have it two to three days, and they have enough volume to justify a fixed unit. So those other two to three days are a big problem. And it's even a bigger problem depending where you are in the state from Sault Saint Marie, Cadillac, Ludington, because it's a cold whether recently the unit cannot get there during the winter months. So we did reach a unanimous consensus that all of those groups including the Economic Alliance, and we thank them for supporting this. And we urge the Commission to give support to the motion to the language which is before you.

CHAIRPERSON TURNER-BAILEY: Thank you, Commissioner Sandler. Any questions or discussion among the Commission? (No response). I do have a couple of cards. Brian Reuwer. I think he was on his way out. You're back. Okay. Great. Brian Reuwer.

MR. REUWER: My name is Brian Reuwer with the Michigan State Medical Society. We are going to take a need for (inaudible) and agree with the Economic Alliance on the standards. The Michigan State Medical Society is fully supportive of the MRI standard, we only caution the Commission on one item. On these particular standards, make a specific case of having nonprofit entities being able to purchase these MRIs under these standards. We would like to urge the Commission to not make this a new standard and to allow other groups, and when we get to other standards along the way, to allow other groups namely in some cases even physician groups not to discriminate against them when considering these standards. Thank you.

CHAIRPERSON TURNER-BAILEY: Any questions? (No response). Barbara Jackson.

MS. JACKSON: Hello, I'm Barbara Jackson, Regulatory Director for the Economic Alliance for Michigan. I am here again to testify in support of proposed standards changes to the MRI standards. As requested by concerned smaller and rural hospitals without fixed MRI service, these proposed changes will specifically address the needs of patients in counties not currently served by fixed MRI units. We feel that by this proposal balances the concerns of patients at smaller or rural facilities that require greater access to MRI service while at the same time preventing excess proliferation of MRI units throughout the state. When there is merit for modifying CON standards, the Alliance strongly believes that it should be done promptly but also with proper technical expertise so that change is done in a way that is deliberative and the solution meets the problem identified. That is why we think the CON Commission process is the preferred way to go and not have corrections made by the more blunt instrument of the legislature. We want to commend the many people who worked so diligently to address this issue, including Commissioner Dr. Sandler, Departmental staff, MHA staff and providers. And we thank you very much. Any questions? (No response).

CHAIRPERSON TURNER-BAILEY: Thank you.

MS. JACKSON: Thank you..

CHAIRPERSON TURNER-BAILEY: Sean Gehle.

MR. GEHLE: Good afternoon. I'm Sean, just representing Ascension Health, and specifically St. Joseph Health System in Tawes. We're very supportive of these changes and appreciate the Commission taking a look at these, and appreciate Dr. Sandler's leadership as well. So I just wanted to indicate our support, and I'll let it go with that. Thank you.

CHAIRPERSON TURNER-BAILEY: Thank you. Any questions? Comments? (No response). Thank you. Are there any discussion? (No response). Is there a motion?

COMMISSIONER DELANEY: I move that we support the proposed revised standard.

COMMISSIONER BREON: Support.

CHAIRPERSON TURNER-BAILEY: Moved by Commission Delaney; support by Commissioner Breon that we approve the proposed standards. And move them forward to public hearing, that's your motion, right?

COMMISSIONER DELANEY: Right.

CHAIRPERSON TURNER-BAILEY: Is there any discussion? (No response). All those in favor please signify by raising your right hand. And we don't have any Commissioner on the phone anymore so that's eight. Thank you. At this time we'll move to the --

COMMISSIONER SANDLER: Can I make a comment?

CHAIRPERSON TURNER-BAILEY: Yes.

COMMISSIONER SANDLER: Yes, I'd like to thank the Commission for supporting this. This does not significantly change the standards of MRI, we want to stress this. This was an exception to improve rural health care only. So nobody should think that there's any significant change or ease (inaudible) MRI or anything like that. The second point that I'm asking the Department on this, I consider this to be a real hardship for rural health care. Is there any possibility that we could have a following scenario, you have the public comment section, it has to be in the (inaudible).Can we then bring this for a final vote at the May 11th meeting? It would only take a few minutes. This would help people get rolling this calendar year.

MS. ROGERS: We could get a public hearing scheduled by April 11th.

COMMISSIONER SANDLER: Okay.

CHAIRPERSON TURNER-BAILEY: We'll try to do that.

COMMISSIONER SANDLER: The public hearing will be very brief. Thank you.

CHAIRPERSON TURNER-BAILEY: Okay. Thank you, at this point we will hear a presentation on evaluation of CON in Michigan. Drs. Conover and Sloan.

(Power Point presentation of Evaluation of CON in Michigan given at approximately 12:48 p.m.)

(Presentation ended at approximately 1:41 p.m.)

CHAIRPERSON TURNER-BAILEY: Are there any questions from the Commissioners? Any questions? (No response). Okay. I have a couple of cards from the public. Patrick O'Donovan.

MR. O'DONOVAN: My name is Patrick O'Donovan from Beaumont Hospital. And I'd like to thank the professors for coming in and providing us with the results of their study. I must say I'm a big Michigan State fan, and my comments have nothing to do with the fact that Duke came in (inaudible) by 20 point in (inaudible). Before I comment specifically on the study, I'd like to reiterate that Beaumont continues to strongly support Michigan CON Program and the CON Commission. Beaumont supports CON for the following reasons, nothing that I read in the Duke study led us to conclude otherwise. First, CON is associated with higher quality. A 2002 study that appeared in the "Journal of the Medical Association" concluded that "Mortality rates for Medicare patients undergoing open heart surgery were higher in states without Certificate of Need regulation. Repeal of Certificate of Need regulations during this study period was associated with decline in hospital volume for open heart surgery." CON is associated with lower costs. General Motors, Ford and Daimler Chrysler all have studies showing their health care costs are lower in CON states than in non-CON states. While the Duke studies dismiss these studies as poorly designed, it is telling us that this studies representing the actual experiences of three different companies and they all reached the same conclusion. Third, contrary to the conclusions of the Duke study, experiences in states that have repealed their CON laws have shown a proliferation of health care facilities, especially for-profit facilities. For example, after Ohio eliminated its CON program, the number of licensed ambulatory surgery facilities increased from 27 to 179. And the number of licensed diagnostic imaging centers increased from 27 to 229. And that was from the report from the Ohio Department of Health. In Michigan, the number of MRIs increased by 29 percent after CON standards were relaxed. Absence of CON paves the way for for-profit companies to enter new markets and strip the local not-for-profit hospitals of services that currently subsidized unprofitable but necessary community services, this is beginning to happen across the country in states without CON. A recent General Account Office report concluded that privately owned specialty hospitals cherry picked the healthiest and most profitable patients leaving financially struggling community hospitals to "bear the brunt of providing the most costly care for the same amount of financial support." The proliferation of for-profit specialty hospitals in states that have a eliminated CON, has Congress so concerned about the future of nonprofit community hospitals that they recently passed an 18-month moratorium on starting any more of these hospitals. But also, if the original Duke study on this topic, which was published in 1998, used data only through 1993 which was before the proliferation of specialty hospitals in non-CON states. A few specific comments on the study itself. First, one of the study's conclusions is that "The empirical evidence regarding CON's impact on cost and availability of hospital beds provides little reason to believe that lifting restrictions on beds would result in a surge of building new facilities." I don't know how one could conclude that would-be case in Michigan. We know of at least three new hospitals that would be built in the Detroit suburbs if CON went away and there would be likely be many more. Second, the study also concluded that "Thus the best thing that can said is lifting CON appears to have no permanent affect on health spending. And if there is such an affect it would be in the negative direction." I found the evidence presented in this section much more mixed, especially since this was a section that included the discussion of the Big three Studies. In addition, this conclusion once counters to another recent study that appeared in the publication " Health Affairs" which concluded that "New pieces in the supply of technology tend to be related to higher immobilization and spending on the service at question." Another statement in the study is said "There appears to be little question that Michigan's CON Program reduces access in suburban

areas." I could find no evidence in the study that supported that conclusion, nor have I heard that general assertion made by anyone familiar with health care access issues in Michigan. And finally, note that while many of the studies were critical of CON, they do acknowledge that "Most key informants, 92 percent favored retaining acute care CON rather than eliminating it." While I can't argue with the methodological design and statistical analogies in the study, I just think it's difficult to draw conclusions about the effectiveness of CON using comparative statewide aggregate data. The study was based on data that was available to them, much of it of all which is probably not the data that they ideally would like to have had. Unfortunately, this is the case with many research studies. In closing, we would agree with the concluding statement of the study which was "What all sides might be able to agree on is that the program can and should be improved so that it obtains its objectives in the most efficient and equitable fashion." Note that the bulk of the study's suggestions for improvements to CON Program were incorporated into PA 619, and have been or are being implemented. Thank you.

CHAIRPERSON TURNER-BAILEY: Thank you. Are there any questions? (No response). Larry Horowitz.

MR. HOROWITZ: We're here, unfortunately, and once again I have a very sharp difference with the Duke University study. The reason I say once again is that some of you heard this two years ago in the context of the House of Representatives Hearing when Drs. Sloan and Conover were with us, and ourselves. I'd like to describe to you particularly the issue of costs because their conclusions and the University of Iowa Study, that's the one reported in MMA posts the literature does say that having high volume fewer facilities who specialize things has a correlation of the quality, and they find that true. I'm going to focus therefore mostly on the cost side of this question. We have members in Economic Alliance who are from small business and rural and Farm Bureau and all kinds of companies, but the autos have the unique burden or advantage of operating in multiple states with exactly the same benefit plan for each company, and almost exactly the same across all three companies. And so I want to talk about that, too. Let me just (inaudible) what our concern is about the methodology which we looked at and the autos look at essentially when whether they did a preliminary study back in mid 1990s, and then did the study that had been added (inaudible) a more thorough basis. Because of a concern of the standard methodology used in academic statistical studies or academic views of the literature of comparative costs. We don't think that really does very much if you look at some of the variable and other studies end up having to use. They usually look at total health care cost per capita. Well, that's not much of a measure for CON because CON never was designed, nor is it now, to deal with majority health care costs. You don't deal with doctor visits, you don't deal with most of outpatient services, it doesn't deal with pharmacy, and so forth. So to say that CON only effects the minor part of the pie and access how much the whole pie grows, it's not much of an effective evaluation. We didn't look a lot at this, we didn't look at one of the (inaudible) because that is very hard to access what the other variables are. The American Hospital Association data on the number of beds, we think, would not be a very useful index because they look at staff beds, not licensed beds. So the (inaudible) beds (inaudible) unused besides, but CON doesn't regulate staff beds, CON regulates licensed beds. For MRI services, I don't think the database that was used is very good for the reason they mentioned is that there is no capture by the AHA or most states on outpatient non-hospital MRI units. Most states that ever regulated MRI only regulated the hospital based MRI, it didn't regulate the outpatient MRI. It didn't regulate the non-hospital MRI, so therefore you group's truly comparing apples to oranges. The multi variant analysis, the statistical analysis, though much attention is given to the report, if you look at the conclusion status of all the pluses and minuses and so forth, you will find it has Zero or N/A in most of those charts that we just saw. It didn't result in conclusive measure. The concerns that I would want to point out that Michigan -- the stringency issue. The used the Lewin Study which really dates, goes back to Tom Piper, the Director of CON in Missouri, where he did this analysis. And we never thought that was a very good assessment. Because to say that state is more stringent because it covers a lot more services without evaluating whether or not it has a very meaningful regulation of each of those services doesn't anything. And as indicated, though, some states have on their records that they regulate MRI or (inaudible) don't particularly do it, it's just a rough count of how many is technically listed doesn't mean anything. The dollar threshold we don't think is a very meaningful indication of stringency. To do what some states used to do and would be regulating, you know, $250,000 finish for x-ray machines or something else doesn't make a difference. In 1988, this state did go two major changes that were different than CON in most other states. Since then, CON regulates everybody who's providing a particular service. In most states it continues to only regulate hospitals. So it's everybody that has a surgical suite, you know, freestanding or hospital. Everyone who has a MRI

machine, freestanding or in an hospital. Most other states they only count or regulate the hospital rates. So in doing that I'd like to refer you to Appendix J in the study where they did print the results of all of the studies. And we'd just like to mention why the --we -- thought that the auto studies were a much better approach. Why? Because it bypassed the problems that the Duke study mentions for comparing things. It takes a population of very similar demographics, people beam who work in auto plants, or retirees for auto plants, tend to have verisimilar health status and tend to have very similar health styles, it's a rather consistent group. And, plus, this was age adjusted in some cases, gender abd other adjustments. To the nature of the benefits you have, whether you have very rich benefit package, whether you have very high or low cost sharing factors clearly has an impact of how much health services you consume. And therefore if you do it just by everyone who live in one state they have tremendous variations in health status, tremendous variations to demographics, age. If you're looking at the just the employees retirees from an auto company they are covered by exactly the same benefits, they have exactly the same cost sharing provisions. So if you look at that and it's (inaudible) and there was some comment about that they didn't provide the data from certain states. They provided all of the data for every state which they have a significant presence. The reason why they don't have data in some place is because some of the auto companies don't have a presence in some of these states, they're presented wherever they have a significant presence. They used three different approaches word in uniform (inaudible). It's striking to us that all three auto companies found the same consistent pattern though why each of them had a different set of states to look at. In every state CON states have lower total cost than non-CON states, including a state that just regulates long-term care was considered by that to not be a CON state. The auto companies don't pay for anybody's long-term care so they don't have any data for that. So the only way you'll see a long term care that if it's the same in terms of their data as if they didn't have CON. I read to you from the Chrysler study. We're talking about maintaining manufacturing jobs in Michigan. The fact that we have the second largest number of manufacturing job loss than any other state in America, why is it some people say is that the Economic Alliance and the auto companies and many others who are monomaniac crazy people in their fixation of CON. It's because of this, it's something that clearly could be theoretic in better ways, licensure, regulate and take beds away (inaudible). But in the legal and political context of the inability to have all those other things done we want to keep the crew tourniquet that we have on the cost factor while hopefully we all can do something better. Quote from Chrysler: Health care cost representative important ingredient in manufacturing decisions made by Daimler Chrysler Corporation. DCC may build new factories, expand to renovate facilities or close factories based in part of the cost of quality of geographic areas. Health care is DCC's largest single component in cost in producing a vehicle. Larger than even the cost of steal. So they looked at these various states, and they're not total states where Wisconsin is not all Wisconsin, it's people who live near Kenosha or Newark, Delaware because people tend to get health services here. If you look at the GM study, and I'm sure Mr. Ball can amplify this if he wants, while Chrysler looked at one year for multiple places Ford -- excuse me -- GM looked at the same issue over a six-year interval. In each of the six years, costs were higher in non-CON states than in the CON states. Then the question can be (inaudible) 'Wait a minute, Horowitz. You're using the same thing you just criticized which is total health care cost spending, right, versus what CON regulates'. But if they drilled them? Ford then had a study in which it looked at the same two services that they looked at: MRIs and PETs. And people say, well, these are two things that are very much regulated by CON. And they found a very significant difference in costs for cabbage in CON states versus non-CON states so that we think that approach of using real dollars, real expenditure numbers is the total cost, the employee and the employer total cost is a better way than the statistical approaches that don't take into accident similarities in health costs-- difference in health costs -- and health benefits and the stringency programs. We think that the program has worked well as (inaudible) to cost savings. Could is it be done better? Amen. That's why we heard today earlier having joined together on PET and CT and MRI and a various of things and they hoped to participate in all these other questions. Clearly there's a definitive indication also. Quality. Weak provide information on that but since that seems to be not as much in debate I just would say it is helpful to costs, it's helpful for quality. And in terms of access we don't find that it hurts the (inaudible) access to say that there are more things out in suburbs where I live and work. After CON is not an indication that there was a need for them, it's an indication there's more profitable opportunities in my county than in other counties, and then you have an explosion of activity. So I think Michigan CON Program has been fine tuned and focused. It deals with a limited number of services but regulates on a fair open basis or regulating every player whether it's for-profit or nonprofit, outpatient or hospital. And we think that the evidence that people look at on a day-to-day basis whether it's the Blues or whether it's the auto companies or other people who are actually

having to pay the bills, I think it's pretty important in terms of looking at the dollar and cents impact. Thank you.

CHAIRPERSON TURNER-BAILEY: Thank you. Are there any questions? (No response). Okay. Vin Sahney.

MR. SAHNEY: I'm Vin Sahney, Henry Ford. I didn't know that we were here to debate the studies. Though I'm not going to do that, although I'd love to debate the two people who presented the data. But I'm really here to ask some questions for the two people who we have invited to present their study. My question is did you compare the cost of administering the CON process both to the provider as well as to the state of managing the CON process? Did you compute that for different states that have who have CON, no CON, for the (inaudible) stringency, so that's question No. 1. And did you look at the prices paid by the employers? If so were there differences in the states where there was no CON for the Blue Cross where they could negotiate better prices with the hospitals, or the state where they could better negotiate. So what did you look at the other side, and so my question is since I don't have access to the study whether you looked at those things.

MR. CONOVER: Well, we did not look at program costs --

CHAIRPERSON TURNER-BAILEY: Can I ask you to come to the mic.

MR. CONOVER: To answer the first question. We did not look at CON Program costs. Actually, in another context I've done a calculation for with the nation CON. And I'll be happy to provide those numbers, for the record. I don't have them in my head. But we did not do that for this study. With respect to the issue of prices paid, we also did not look at that either. But it's an important point competition. Competition makes a difference. And that's one other thing I wanted to say is that it's real hard to incur costs from what the supply of things. That is you would not incur the costs of gasoline by observing the number of gas stations and saying 'oh, there's more gas stations, therefore, people must be spending more on their gasoline. Typically the reverse would be true. When there's is more competition prices go down and total expenditure end up being (inaudible).

MR. SLOAN: Some of the majors would reflect the price of care, but we did not look at charges per se. The other thing is just to be sure that there's is no confusion, we looked at many depended variables. We did not just look at acute care costs. And we put up on the board the variables that we did measure. We didn't just do that, and that's not factually accurate. The other thing is that we would love to analyze the companies' data. I'm sure other annalists would love to analyze the companies' data. I mean it's not-- maybe they're right and we're wrong. The problem is we don't have access to those data. And we've always sort of held up somebody else's side and we don't agree with the methodology, but we feel sort of frustrated that we're not able then to say 'Well, let's try our methodology, let's their data and see'. Maybe it stands up. It would be much stronger than having it where you have interest represented, you know, doing analysis. It's much better to have a separation. So we don't really-- we say this is what we found with our data. We would love to have other data to confirm or review our own work.

CHAIRPERSON TURNER-BAILEY: Cheryl Miller.

MS. MILLER: My name is Cheryl Miller, and I'm Senior Manager in Trinity Health's corporate Strategic Planning Office. And unlike the vast majority of folks here today, I concur with our guest from Duke, that the ACC has far superior basketball than the Big 10. And especially want to highlight the fact that my beloved alma mater Georgia Tech beat Duke (Laughter).

MR. SLOAN: Thank you for mentioning that.

MS. MILLER: Thank you. It was my pleasure. Trinity Health is the nation's third largest Catholic health system with 45 hospitals in 7 states from coast to coast. And although we do have 12 hospitals in Michigan we also have hospitals in Ohio, Indiana, Iowa, Maryland, Idaho and California. Three of these states have CON laws; Michigan Iowa and Maryland, while the other four do not; Ohio, Indiana, Idaho and California. In Ohio concern about the waning fiscal health of its hospitals as well as the over-saturation of these services. The number of specialty hospitals, ambulatory surgery centers, diagnostic

imaging centers, radiation therapy facilities continues to grow, especially for the for-profit facilities. Notwithstanding this growth of for-profit services and facilities but pressure to meet shareholder rate of return requirements negates the ability of these facilities to provide uncompensated care to low income uninsured individuals who are not eligible for any public or privately underwritten health care coverage program. At the same time, the proliferation of for-profit services and facilities weakens the financial ability of full service community hospitals to provide uncompensated care. These phenomena which are signature features in states mom without CON requirements reduce access to community care. In Indiana, the senate is currently considering the return of CON in order to limit construction growth. General Motors and Daimler Chrysler, who back their concerns with documented increase health care costs, have led this effort. Daimler Chrysler has reported that their health care costs in Indiana are 89 percent higher than New York, a CON state; and 32 percent higher than Michigan, another CON state. Trinity Health continues to support a strong CON program in Michigan and wishes to commend the Department for significant process improvements over the past couple of years. If the State of Michigan is committed to community based health care as opposed to entrepreneurial based care, CON will remain a vital part of health planning in the state. Thank you.

CHAIRPERSON TURNER-BAILEY: Thank you. Are there any questions? Any further questions or comments? (No response). Lody Zwarensteyn.

MR. ZWARENSTEYN: Thank you. I'll make this very, very brief. My comments are occasioned by a recent move of the Alliance. I really want to thank the Duke researchers for coming out. They mentioned something that triggered a thought. We had the luxury of their being able to update previous studies so I assume it didn't cost an arm and a leg (inaudible) to do a review here in Michigan. But that updating of the study does trigger a thought. In our move of our offices, I cleaned out our library and I find found several examinations of the CON Program in Michigan paid for by the State of Michigan. I noted that several of the recommendations made by our researchers from Duke have already been implemented. With the change in the CON law there has been movement, and I hope that we'll continue to make movement along the with several of the recommendations that were made. But there were other recommendations in other, and being one who hates waste, I certainly hope the CON Commission would direct the Department to go back to its own studies that it paid for with other consultants to the State of Michigan to look at, evaluate and recommend improvement of the CON program and measure whether in fact those recommendations were ever implemented, to what extent and so forth. Many recommendations it made over the years and take one study in isolation doesn't do much but I think it would behoove the Commission to take a look at the broad range of studies that have already been done and take a look at updating those as well. The other thing I would like to put on the record, in a recent public forum sponsored by the Alliance for Health two weeks ago, a question was specifically posed to the Governor of the State of Michigan "Do you favor the Certificate of Need Program? " And our Governor did reiterate her strong support for CON in Michigan. And I felt it's something I think you should consider even on the record, but that's a comment. I will give you have the transcript. It's been on network television, cable television, many other forums already. But I'll get you the transcripts very shortly. Thank you.

CHAIRPERSON TURNER-BAILEY: Thank you. Any questions?

COMMISSIONER SANDLER: I have a comment. Lody, you're a man of credibility. We don't have to (inaudible) any evidence.(Laughter). Especially since I heard the Governor say that in a different conversation. So at least there's two people in this room that have heard this and I suspect that Mr. Christensen, Mr. Hart and Mr. Horvath have heard the same thing. (Inaudible) we have this meeting. I just want to make a general comment. I appreciate the study from the two professors from Duke. And as far as the comments made after that, those comments are anecdotal. One of the problems with the comments of somebody who reads the Peer Review Medical literature, unless this is peer review anybody can stand up and say anything they please. I'm been one of the (inaudible) that's what people will do. They say things that have no peer review. And actually to buttress that argument some of the things going on in Ohio that they want to have specialty hospitals and better cardiac care in specialty hospital there's especially no evidence that a Peer Review would even support that either. I mean, anything can this case if it's mainly an academic discussion (inaudible). This is two people's opinion who were neutral, by the way, we did not have an (inaudible) to investigate. I mean, you should remember that. As far as I know they didn't have some agenda to come up with the conclusions. And people who wish think this

conclusion (inaudible) they have to be willing to submit their material for Peer Review so somebody can see what they've done. That is the only comment.

CHAIRPERSON TURNER-BAILEY: Thank you. Any other further questions or comments? (No response). Jim Budzinski. I'm sorry. Mr. Christensen.

MR. CHRISTENSEN: I just want to echo that I also heard the Governor say in many occasions that she supports a strong CON Program. I would further indicate that it's important that the Program be based to that extent that we have the ability to do that on science and our rationality. And the presentations of these gentlemen today help bring perspectives to us which we can consider. I think if they were amended or ended, I think she would clearly be on the process of let's improve it. (inaudible) big problems if there are problems and let's move forward. Again, (inaudible) science, I think if you have a Governor who strongly supports the CON Program.

CHAIRPERSON TURNER-BAILEY: Thank you. Budzinski.

MR. BUDZINSKI: Good afternoon. My name is Jim Budzinski. I'm the senior vice president of finance for Sparrow Hospital and Health System. I will be brief, I do not tend to keep us any longer than necessary. I just want to make sure I go on the record on behalf of Sparrow Health System to inform the Commission that Sparrow Hospital and Health System has long supported the Certificate of Need Process in Michigan, continues to support it in its current fashion. We are an amended organization where necessary where it meets the needs of the state and the health planning areas in the state. As a practical matter Sparrow Health System Board of Directors views the Certificate of Need Process as a process to rationalize systematically how to invest in costly activities such as facilities and technologies; and to do that in the most systematic way most possible to minimize the cost of providing health care in the state not only today but in the future given the very limited resources of health care dollars today that we're all faced with whether it's federal budgets, state budgets, local organizational budgets, etcetera. With respect to the Duke study, our belief is that there's many other credible studies out there that we've seen and read that clearly support there's a relationship between stringent Certificate of Need processes and the cost containment process. Regarding the issue of measurements in the Duke study about per capita health care, etcetera, I would echo what my colleagues said in my colleagues statements. The real issue is facility costs and data supporting facility costs in comparison with states that have CON and who don't. Quite frankly, information is readily available in my opinion. In this state, for example, every Blue Cross, every HMO state have to file reports with the Office of Financial Insurance Services, O.F. I. S. every quarter. And you can measure the last 10 years of facility expenditures for every insured health (inaudible) in the state, and do that for other similar states who don't have CON processes, and you can probably come up with some very incurable data would be similar to the Chrysler, the Ford and the GM studies. With that I'd take any questions.

CHAIRPERSON TURNER-BAILEY: Thank you. Are there any questions? (No response).

MR. BUDZINSKI: Thank you.

CHAIRPERSON TURNER-BAILEY: I too would like to thank the researchers from Duke for coming all the way up here and getting bashed by all will Michigan State people, (Laughter), and presenting your findings. We appreciate it. We've been waiting to hear all the results of the study and appreciate the work that you did. I know that you're on a tight time schedule so I think we've taken you all the way up to the last possible moment, so we appreciate you coming. Thank you. Next item on the agenda New Medical Technology. Brenda.

MS. ROGERS: There's nothing new to report.

CHAIRPERSON TURNER-BAILEY: Nothing new to report. Compliance Report.

MS. ROGERS: I'm going to turn that over to Bill Hart.

CHAIRPERSON TURNER-BAILEY: Mr. Hart.

MS. ROGERS: Jan. I'm sorry.

CHAIRPERSON TURNER-BAILEY: Mr. Christensen.

MR. CHRISTENSEN: He will tell me what he's going to say. I'm happy to read the Compliance Report. Some of you may have seen some articles in the newspaper about facilities to be opened in the southeastern Michigan area that would be on alleged community trust land which would provide MRI and certain other services that would not need a Certificate of Need (inaudible). As a matter of compliance action, we did notify the Attorney General and the Governor official staff. We did send letters out to the facility owners and the operators of the facilities and did go out and do inspection of the facilities. And they're not operating. They've agreed not to operate. We have a meeting scheduled with them with the tribe itself and the tribal chairperson and the council, and we're optimistic that we'll get that solved within a context of the Michigan regulation for CON. So that's a good news.

CHAIRPERSON TURNER-BAILEY: Thank you. Does that complete your report? Okay, thank you. Are there any questions?

COMMISSIONER SANDLER: Yes, I have a question. After you fix that problem are you going to stop them from selling cigarettes (inaudible) (Laughter). That ought to be the next problem that you ought to fix.

CHAIRPERSON TURNER-BAILEY: Legislative Report.

MS. ROGERS: None today.

CHAIRPERSON TURNER-BAILEY: Okay. Thank you. Commission Work Plan. Brenda.

MS. ROGERS: I'm going to quickly go through what I'm showing and then we can discuss any other changes or additions or whatever. We will be removing Air Ambulance Services, and the final action was taken. The Bone Marrow Transplantation Services will be removed. Cardiac Catheterization will be removed. CT will be removed. Heart, Lung and Liver Transplantations will also be removed. Hospital Beds will remain on the work plan. MRI Services will remain on the work plan for the new issue that's being put forward at the public hearing. MRT still remains on the work plan, and that's still we're in the process. NICU will come of the work plan. Nursing Home, that one that I would question with the Commission. That technically could come off but I know there is an informal work group working on some items so you may want to think about that one. Open Heart Surgery Services will come off at this point. At a future time there still is an outstanding issue to take a further look a the pediatric definition which is just a carry over from when those standards were last revised. But for right now that will come off unless the Commission decides otherwise. Pancreas Transplantation Services will be removed. PET Scanner services, actually I believe should remain on the work plan because again in the standards there is a requirement that the PET Standards be reviewed beginning, I think it's like, March 30th -- March of 2004, so you may want to keep that on the work plan for future work.

CHAIRPERSON TURNER-BAILEY: Can with we let just get through with that and then we'll have time for discussion at that point. Thank you.

MS. ROGERS: Psychiatric Bed Services, that will come off the work plan. Surgical Services remains on the work plan. Litho will come off the work plan and then as standing items New Medical Technology remains. And 2002 PA 619 Sections require CON Commission action remains on the work plan.

CHAIRPERSON TURNER-BAILEY: Okay. Thank you. Dr. Sandler.

COMMISSIONER SANDLER: I have two questions. The first one is -- actually comments (inaudible).My fellow Commissioner wishes to comment upon. We heard an earlier comment, public comment by MR. Dobis, I believe his name is from McLaren, about some technical issues regarding PET mobile (inaudible). There are a number of issues which primarily touched at home and now that is probably putting regular services out for PET. There's some problems about that you have precisely the correct standards. Which I understand them but I don't know what group was writing those PET standards a few

months ago.(Laughter). But perhaps they didn't have the experience on the practicality of doing this. It's a sharp group but they didn't know this. There's a time that we look at this to correct the technical issues any standard advisory committee (inaudible) appropriate. And it's a good number of issues that probably need to be addressed for efficient care. What does the Department like to do, what would probably be the best way going about addressing the issues that were raised (inaudible) CON Commission?

CHAIRPERSON TURNER-BAILEY: Well, I don't know if the Department has any comments on that. I know that we are at the point where it's supposed to come around again for us to review this. And I think, you know, relative to our capacity for handling issues and the Department's capacity for supporting our handling of those issues we certainly need to consider where to put that issue. I'm not sure whether we're ready for a standard advisory committee on this at this point. And this is my recommendation that leave it on the work plan, certainly address it and do it in, you know, a timely manner of course, or in a way where we can address all the other issues that we have going on at this point as well.

COMMISSIONER SANDLER: Okay. Here is a suggestion. Perhaps MR. Dobis and others have some problems with the PET standards and need to meet with the Department. And then perhaps they need to come back to this Commission with recommendations to address these issues. And my other comment on that is that I believe that maybe not a public meeting but at least needs to be some sort of posting somewhere that we are (inaudible) so that people have some concern they could write or call or whatever, and then the Department can look this over and make a recommendation with appropriate writing to the Commission. If you have a handle on that one that's fine.

CHAIRPERSON TURNER-BAILEY: Well, and everyone has the opportunity to come here the same way who did earlier today and talk about some of the issues and make recommendations on stuff that you might want to consider and take to address those issues. And I don't think anyone is shy about taking advantage about coming before us.

COMMISSIONER SANDLER: Before we have type of committee to address that issue what would be better than the standard advisory committee (inaudible) or whatever, that's fine. But I think the issue needs to be addressed.

MR. DOBIS: It is rather a timely issue as

we been, you know, in the PET standards right now. We're starting to face these. And really it is an issue of increasing the costs, the system's unbelievable increasing costs because we can't service those patients through the normal (inaudible). Things that weren't decided in the wisdom of the first commitment because no one had the experience, no one knew how these was going to shake out (inaudible).

COMMISSIONER SANDLER: In spite of a very wise person.

MR. DOBIS: A very wise person.

CHAIRPERSON TURNER-BAILEY: Are any other questions, any other comments relative to the work plan? Is there a motion?

COMMISSIONER GOLDMAN: I move to --

CHAIRPERSON TURNER-BAILEY: I asked for a comment and then I didn't give one. I do have a comment on the Nursing Home and Hospital Long-term Care piece, we should leave that on the work plan. And I think you kind of left that out there for us and I certainly think that should be left on there. Mr. Christensen.

MR. CHRISTENSEN: Yes, we recommend that it be left on there. We've recently had some inquiries from a variety of people in long-term care field and the nursing home field. They're a nonprofit organization and for-profit (inaudible). And we've though about issues related to mainly facility standards, how can we allow nursing homes that we have to evolve into what is becoming a state of the art type of nursing facility, which is quite different than a lot of the nursing homes that we have in the state right. A

lot of them are 30 to 40 years old. It was built in a different time and a different perspective. At that end Commissioner Cory has been meeting informally with some representatives of various groups involved in long-term care to try to crystallize what the issue might be. And I would hope that we'd be able by the next Commission meeting bringing some type of report back to the Commission of what the issues can reached. Then we figure out what direction the Commission wants to go on.

CHAIRPERSON TURNER-BAILEY: Commissioner Goldman, were you prepared to make a motion?

COMMISSIONER GOLDMAN: Yes. I would move for approval for the work plan specifically nursing home (inaudible).

CHAIRPERSON TURNER-BAILEY: And that would leave to delete those items that --

COMMISSIONER GOLDMAN: That's correct.

CHAIRPERSON TURNER-BAILEY: Okay. Is there support?

COMMISSIONER MAITLAND: I support it.

CHAIRPERSON TURNER-BAILEY: Support by Commissioner Maitland. Any discussion?

COMMISSIONER MAITLAND: Yes, I wasn't sure on the open-heart surgery, the pediatric part, you know, we're removing that completely but we haven't resolved the issue. Is that a separate issue to resolve now that we don't have to have ad hocs, or I can't remember?

MS. ROGERS: I'm not sure how simple of an issue it is. But I know what needed to be looked at went beyond the charge of that original Ad Hoc had done. And there's a lot of -- what I'm understanding, there's a lot of technical expertise that's basically going to be needed on that because I think there's some controversy as far as that definition in which way it should go. I'm not sure if it's going to be a quick fix so at this point the recommendation is to remove the standard from the work plan, but if the Commission certainly feels they want to leave it on to possibly look at, you know, at some point.

CHAIRPERSON TURNER-BAILEY: But we can always put it back on.

MS. ROGERS: Yeah, you could always put it back on.

COMMISSIONER MAITLAND: Thank you.

CHAIRPERSON TURNER-BAILEY: Yes. Mr. Horowitz.

MR. HOROWITZ: Larry Horowitz. I just want to make one comment about the pediatric heart surgery issue. I'm sure you're familiar with the Alliance publishing a brochure about providing data every year in a little more timely, we can sample certainly that on the pediatric open heart surgery. I recommend that the Department ask the people who've expressed a concern about this to reduce to writing what their concern is. I'm sure the comparable Dr. Sandler's suggestion regarding the PET issue. The reason I say that is the best I can understand about the conflict is there's some pediatric heart people who practice at hospitals that have a pediatric CON for open heart surgery who believe that it's quite inappropriate for someone with a congenital heart problem, certain categories, to be taken care of at adult open heart surgery programs. This is not a question. You know, so if I'm 64 -- 62 years old and my problem is congenital, I've had it since birth and it's of a certain specialized nature, they would argue that this person should not go to Henry Ford Hospital for adult surgical, they should go over to Children's because it's something that a pediatric surgeon would know better about. Others say, well, it's really not a very useful thing to put a 62 year-old person in a hospital catering to people from 0 to 14 or 0 to 18, and we can rely on adult service to do that. This is a very different issue than the normal Certificate of Need issue about volume and everything else, there's really a question over, you know, who's the right place to go to. I'm not terribly sure that CON can do that. If I've been taking care of, you know, it's a question then sometimes -- it's very hard to know whether someone has a congenital heart problem until after you've opened them up, right. You don't really know what the nature of the problem. It's a very different CON

Program. It's a really a turf question of who it should be. So I would recommend that you follow Dr. Sandler's suggestion of have them put in writing what it is and make a prudential judgment of how to cope with this. Because I think it has just some terrible -- some very troubling -- implications. Until now basically if someone's been over the age of 14 or 18, whatever there is, you've allowed them to either go to a pediatric place if they so choose and consult a physician, or go to an adult place and not end the question whether there's certain places that should only be taking care by pediatric doctors even though they're of significant age. Thank you.

CHAIRPERSON TURNER-BAILEY: Thank you.

COMMISSIONER SANDLER: Now, I have a comment about that issue. I apologize, I had to leave for that issue. I certainly concur with the action that was taken and I appreciate everybody who worked on that. From reading all these letters, however, from west Michigan about some of the things that they said were very appropriate. I'm certainly not defending about Michigan doesn't need CON blah, blah, blah, let's forget all of that which was inappropriate. They did raise an important patient care issue. The patients in west Michigan can't get a level in a timely manner. They're putting in stints and a whole bunch of things. And it wasn't one time, it was the entire west coast of Michigan in St. Joes, in Grand Rapids, Cadillac Muskegon, there was a whole (inaudible). The recommendation I made, and is just an informal comment, if somebody want to get to a PET or MRI, they made change in the standards and a change in the standards may correct this entire problem. I would only ask the Commission, since these people made such a fuss about this and this is the care of human being that we monitor this with the change, there will be some new mobile routes. Perhaps a year from now the Commission, just as an informal comment, to look back at on this issue to make certain people adopt appropriate (inaudible).

COMMISSIONER GOLDMAN: Yeah, that action was part of a motion that I made and part of the discussion that we had.

COMMISSIONER SANDLER: Okay. Thank you. Again, I apologize for not being here.

CHAIRPERSON TURNER-BAILEY: Okay. There's a motion on the table which has been supported to accept the work plan with the recommended changes. That's for public comment. All those in favor signify by raising your right hand. Future Meeting dates. Our regularly scheduled meeting is May 11th, followed by June 15th, September 14th and December 14th of this year. Actually it says June 15th, 2003. We just want to make sure it's 2004. As you know, you added a May 11th meeting in anticipation of the fact that we were going to have many issues to deal with there may be complex issue, to give the Commission an opportunity to deal with these issues and things like that was a very good idea because I think we're going to need that meeting. At this time I will call cards for public comments. Representative Virgil Smith.

MS. ROLLINS: I'm Virgie Rollins and I'm with the Rollins Group. And Representative Virgil Smith is working with us. I want to thank you, Madame Chair, and the Commission for allowing us to come towed to present this critical issue. We've been working with the Governor's and the state rep. And I'm asking Clarks Busse if he come and give the overview and then I have prepared some comments to read.

CHAIRPERSON TURNER-BAILEY: Okay. So you're going to just follow right after him, I don't need to call?

MS. ROLLINS: Yes.

MR. BUSSE: Thank you, Madame Chair, Commission members. I'm Chuck Busse. I appreciate the opportunity to spend a moment with you this afternoon. Certainly the Commission has absorbed testimony this afternoon about the Certificate of Need Program as it's practiced and administered in the state and one of the States of the Union do. But perhaps the issue in terms of how service is provided on the ground in this state is not so much to the Certificate of Need process but do the database used to determine need when this Certificate of Need is issued by the appropriate offices of the Department. And specifically although testimony suggest that there might be one approach or another that might be more appropriately administered the Certificate of Need really there can be no denying the reality of how the Certificate of Need Program is administered in the state. And we will be offering testimony in the next few

minutes on a specific circumstance in a specific part of the state, in a specific reality and that is on the state border of Ohio in the County of Monroe. In the County of Monroe which has currently one fixed MRI, although we understand the like of it is that soon that there may be another there at the hospital. The reality is that on the state border with Ohio and the smaller towns that border the state, there are no less than 25 MRI machines right on the border. And not jut that that phenomenon exists which says some things that we're going to talk about in a moment, but that they are serving primarily Michigan residents. This is a developing circumstance that has improved circumstance over the last few years since Ohio moved away from the Certificate of Need Program, but it is a reality that suggests that a very strong look at the database must be taken by the Commission. And that the appropriate fashion to service Michigan resident, the appropriate fashion of preserving Michigan economy is to adjust the database to allow for this phenomenon and for these Michigan residences going to Ohio to get appropriate services by Michigan physicians, by Michigan radiologists at Michigan facilities, whether they're for profit or not for profit. Regardless of that dynamic that it be in Michigan and that the economies of this state and the jobs of this state be preserved. Thank you.

CHAIRPERSON TURNER-BAILEY: Are there any questions? Thank you.

COMMISSIONER SANDLER: I have a question. In reading this open style MRI facility available there as opposed to the more antiquated -- you don't want to antiquated is not correct. An open style is not an approve (inaudible) part of an MRI scan. In fact, it's the opposite. An open style has a lot of limitations technically that closed scanners do not have. It isn't a lesser scan, it cannot do all the applications of the closed scan. The advantage of an open scanner is it shouldn't send the population across the border. The work "antiquated" you've got (inaudible).

MR. BUSSE: Duly noted.

MS. ROLLINS: I'll just read comments. But (inaudible) with the Governor's staff, and this is the result of it. Just below the Michigan border with Ohio, there are numerous Ohio cities such as Sylvania, Toledo, Maumee and Oregon that have unusual large number of MRI machines. The city of Sylvania, which has a population of under 19,000 people, has nine MRI facilities. Monroe County has only one. Michigan patients are given the option of either waiting over 30 days to have a local scheduled exam that might be in the late hours of the night or early hours of the morning, or driving to Ohio to have the exam done on a timely basis during normal business hours. The majority of these exams come from Wayne, Oakland, Washtenaw Counties and from Ontario, Canada. Patient care suffers for those Michigan residents who are forced to delay essential medical care. Quality control suffers for those Michigan patients who elect to be serviced in Ohio. Local physicians traditionally have a critical and trusting bond with the radiologist interpreting the MRI exam. These same radiologist, however, since they are not licensed to practice in Ohio cannot be made by paid for readings these exams performed in Ohio. The ability of the surgeon to personally interface with the interpreting radiologist in Ohio is compromised. Likewise, the patient quite often suffers financially because he is seeing a provider in Ohio who is not a member of his or her health plan. The Michigan health insurance companies also suffer because they do not get the economies that are negotiated with the Michigan health provider. Consequently, they pay more for service rendered in Ohio than those same services in Michigan. In many instances, the individual from Michigan going to Ohio facility is faced with a higher co-pay obligation that he would have faced if he would have gone to a Michigan facility. This say major health care problem for Southeastern Michigan, correcting this problem is nearly impossible under present regulations because the thousands of that are referred to Ohio are not reported to the State of Michigan for inclusion for of its database of MRI exams. As you know, in order to get a Certificate of Need the database must show enough exams to justify the need. Michigan requires the in-state MRI facility performing an exam to report volume to determine need, but this does not apply to Ohio facilities and totally ignores all Michigan originated exams performed in Ohio. The omission of these exams from the database insures that Michigan cannot add capacity while Ohio continues to thrive by preying on Michigan inadequacies. For example, the lack of capacity for MRIs within the state also impact the future patient treatment. The existing units are so strained from the capacity that the new development in technology capabilities are overshadowed by the need for patient output. Recent advancements in cardiac and neurological application are often not available to Michigan residents because the clinical community does not have access to enough of the newest technology. Michigan sacrifices financially for benefit of Ohio. Based on market research as much as 100,000 per day is being spent on Ohio MRI facilities by Michigan residents. Using a conservative estimate of only five days a

week of operation over a year, this amounts to 26,000 moving from Michigan residents to Ohio facilities. In addition, the State of Ohio, not the State of Michigan, is the major recipient of the dollars spent by these Michigan residents while they are in Ohio. Also, Michigan does not collect any property tax nor does it collect any income tax generated by the employers or employees in these facilities. Michigan gets none of the benefits of increased work force and its subsequent spending of these dollars in Michigan communities. Likewise, Michigan gets none of the benefits of Ohio suppliers providing for Ohio operations. Michigan does not receive salaries -- sales tax revenue. The total purchase price of the equipment in each of these facilities is upward to $2,000,000. And this is part of a research. And we've been working with the community in Monroe. And I'm going to ask state representative Virgil Smith's Chief of Staff if she would come and do the comments from the State Rep.

MS. TOMPKINS: Good afternoon, ladies and gentlemen of the Commission. I know that it's been a pretty long day so I'll try to be breach as possible. My name is Tanisha Tompkins, I'm Chief of Staff with State Representative Virgil Smith in the 7th District of Detroit. The Representative was here earlier today, however, do a very important vote being taken up this afternoon on the House Session floor, he had to depart. And I will be therefore delivering his testimony in his place. The evidence is overwhelming that thousands of Michigan residences and millions of our dollars are flowing across the state border into northern Ohio. It should be noted that Ohio abandoned its certificate of Need highway process allowing the issuance of MRI licenses to flourish. Michigan and the Department of Community Health remain strongly commented to the CON process to insure that health care supply does not exceed demand that health care costs are controlled and that health care quality is maintained. Arguably, health care quality and health care costs in northern Ohio are compromised by the absence of CON and over-saturation of MRIs. Arguable, in northern Ohio, health care supply exceeds health care demands. The facts show otherwise. The average cost of an MRI service in the northern Ohio facilities is up to $200 less than the cost of an MRI exam in Michigan. Radiologists who read the MRIs in northern Ohio are state certified. This verified by Michigan physicians. Northern Ohio MRIs are fixed and busy. Michigan residents report waits in Sylvania, Toledo, Maumee and Oregon despite the cluster of MRI facilities. Michigan Compiled Laws, specifically Public Act 619 of 2002, provides provisions for waiver from the Certificate of Need process for MRI services. It states: A person seeking to acquire a fixed MRI service within a county that has a population of more than 160,000 but does not have at least two MRI units may file a letter of intent with the Department prior to the acquisition of a fixed or mobile MRI unit within that county instead of obtaining a Certificate of Need. Recent data from the Detroit Free Press demographics department indicate that the population of Monroe County greatly exceeds 160,000. The Michigan Attorney General, however, notes that Monroe County has a population of 157,000 according to the last census. In the past, the Attorney General has defined population count per statute as based on the last census. The Attorney General is reviewing that standard. The truth is that only one explanation for this phenomenon of 20 to 25 MRI facilities in northern Ohio at the Michigan border and thousands of MRI referrals from Michigan to these facilities is substantial and verifiable need. Therefore, it is recommended that the Certificate of Need Commission convene immediately to reevaluate the Certificate of Need database; that the database be revised to include Ohio referrals by Michigan physicians; that amendment to Public Act 619 of 2002, specifically the waiver be amended to lower the population requirement from 160,000 to 140,000 to allow other rural Michigan counties access to MRI health care quality; that the Certificate of Need determine a finding that the Department may waive otherwise applicable provisions of MCL 333.22235 and issue an emergency Certificate of Need for the minimum of two fixed MRI machines in Monroe County; that this finding under provision of Section 22235(1)(A) shows specifically the necessity of immediate or temporary relief due to unforeseen safety considerations occasions for the health, safety and welfare of Michigan residents, as well as the serious adverse effect of delay, the lack of substantial change in facilities or services currently existing after a necessary and appropriate review. Last but not least, that the Attorney General's office be requested to take census market demographic and support data to determine population figures for application of provisions of that waiver.

CHAIRPERSON TURNER-BAILEY: Thank you. Are there any questions? (Off the record at 2:48 p.m.) (On the record at 4:49 p.m.)

CHAIRPERSON TURNER-BAILEY: Mr. Styka.

MR. STYKA: Thank you. Just a couple quick comments because some of what the representative is asking for has to be done by the legislature, not this Commission and not by the Attorney General's office.

Specifically, I was asked and issued in March of 2003 a memorandum of advice to the Department on the issue of the interpretation of Section 222.24(A), which was talked about in the public comment. That section states in the legislature that it only applies to counties that have at least 160,000 people. The legislature many years ago in MCL 8.3(b) adopted a law that's been applied for as many decades that I've been aware that, which total three now, that says that: The population of the state or some political subdivision thereof, which would be a county, shall be determined unless otherwise specifically provided for in the law on the basis of the latest federal decennial census proceeding the time of which the population is to be determined. So there is no choice by this Commission or the Department because the legislature has said in MCL 8.3(b) that you have to use the 2000 census numbers. And the legislature did not, in adopting 2003 Public Act 619, provide an exception to that, which it could have. So that's why Monroe county does not qualify because at this time in 2000 it did not qualify in the population. The legislature can fix it but the Attorney General cannot and this Commission can't.

CHAIRPERSON TURNER-BAILEY: Thank you. Commissioner Sandler.

COMMISSIONER SANDLER: I just have several comments. One is of clarification. You said radiologists reviewed the MRI in northern Ohio are state certified. There's no such thing. I think you mean license. They have a license in Ohio while the Michigan physicians don't have a license in Ohio. Even if the Michigan physicians did have an Ohio license and they (inaudible) in Ohio that has a radiologist, that person by definition would interpret would the MRI anyway. So even if a Michigan physician in Monroe had Ohio licenses it would change anything. Just to clarify that not. The other question, and maybe Amy can help the Representative's office with this. Mr. Wakeman, who is the CEO at Monroe Hospital did attend the meeting, made some of these same arguments about why the business going to Ohio costing more as to why they needed a rural exception. They couldn't give the snow argument of Sault Saint Marie, so that was their argument. And he said, well, they have 4,500 or 4,900 units (inaudible). And we said fine. So they now have an MRI. Now how many days did they have an MRI, how many days do they have a mobile MRI now and what is the change that we just gave them, that is the first question to clarify this?

MS. BARKHOLZ: Are you asking that question of me?

COMMISSIONER SANDLER: Yes.

MS. BARKHOLZ: I'm Amy Barkholz from the Michigan Health and Hospital Association. I'm not sure. I seem to recall Dan Wakeman saying that they had a mobile route that came in about three days a week but he would have the answer to that question.

COMMISSIONER SANDLER: Well, my question, again, just to clarify this is are you asking that there be two fixed units in Monroe County.

MS. ROLLINS: That's right. Last year we had data from doctors and 30,000 patients went from Ohio from the MRI that could have been Michigan. And that's from Monroe County to Ohio. So we're asking for a recommendation from --

COMMISSIONER SANDLER: Let me just -- I'm not saying yes or no. I'm just saying that can you clarify this slightly with the action of the Commission take taken earlier today Monroe County would have one -- Monroe Hospital, not Monroe County -- Monroe Hospital be given a fixed unit if everything else plays out which is why--

MS. ROLLINS: Can you to explain the data part of that if the data then supports --

COMMISSIONER SANDLER: Yes, I can.

MS. ROLLINS: Okay.

COMMISSIONER SANDLER: It wasn't based on the demographic data you have supplied. This was based on an adjusted number of the MRI exams performed. That hospital does about 4,900. And we

change the standards so if you do 4,000 and if you're a rural hospital it would be fine, no fixed unit within 25 miles etcetera, etcetera, you can get a fixed unit. So they won't be getting a fixed

MS. ROLLINS: How is it that we can get another -- that's what I'm trying to get one more fixed --

COMMISSIONER SANDLER: You're absolutely correct. And that's a separate problem. I'm just trying to clarify what's been done. So you don't need two additional units?

MS. ROLLINS: We need one additional unit.

COMMISSIONER SANDLER: Bingo. That's why I want to be clear about that. Because you got one independent that wasn't on the presentation today. If everything plays out. That's all I wanted and I just wanted to clarify.

CHAIRPERSON TURNER-BAILEY: Are there any further questions or comments? Peg Yokom.

MS. YOKOM: Good afternoon. My name is Peg Yokom, I'm the administrator of the Harbors Health Facility in Douglas. We're a still nursing facility. Our facility is located in Allegan County. Allegan County has an excess of 91 Medicaid beds. We're located 13 miles from Holland which is located in Ottawa County. Our service area is Holland. Our facility had 42 inquiries for placement in Holland in the month of January 2004. All were denied admission for not having an available bed. Holland is located in Ottawa County has a need of 78 beds. Our facility currently has 30 beds, all private rooms with private bathrooms that we would like to certify for nursing beds for Medicaid recipients. Since Allegan County borders on Ottawa County and we share referrals, residents and area served, we are requesting that these two counties be combined to form one planning area. We understand that a precedent exists for our request in Houghton and Keweenaw Counties. If our request is granted, we would able to submit a CON to request 30 beds from the current need of 78 beds in Ottawa County. Also, we would be providing a great service to the Medicaid recipients by promoting dignity and quality of life with a private room. We would also be supporting the Michigan Dignity Model for Nursing Home, which has been presented to the Commission by HCAM. We are asking consideration to be given our request to combine Allegan and Ottawa Counties as one planning area. By granting our request our facility will be able to enhance the quality of life to 30 residents who are seeking nursing home placement. By granting our request, we would be able to meet the current bed need in Ottawa County at a minimal cost by utilizing 30 private rooms that already exist. We understand that the first that the step in the process in developing our request, is that the CON Commission may convene a standard advisory committee and we would be volunteering to be a part of that committee. Thank you very much for your time.

CHAIRPERSON TURNER-BAILEY: Thank you. Are there any questions? Just one quick question. I'm sorry. Commissioner Cory has a quick question for you.

COMMISSIONER CORY: Do both the counties qualify as rural counties?

MS. YOKOM: I believe they're both rural. I would have to check.

COMMISSIONER CORY: According to the CON guideline.

MR. HOROWITZ: No. Ottawa County is part of a standard metropolitan statistical area, Allegan is not.

COMMISSIONER CORY: Thank you.

CHAIRPERSON TURNER-BAILEY: Okay. Thank you.

MS. YOKOM: Thank you.

CHAIRPERSON TURNER-BAILEY: Scott Leete.

UNIDENTIFIED SPEAKER: Scott had to leave. But he's in agreement with Mr. Dobis so he's going to work with the Commission on the -- work with the department on the fact sheets.

CHAIRPERSON TURNER-BAILEY: Okay. Thank you. Larry Horowitz.

MR. HOROWITZ: I hope to God I'm last I'm sure everybody thinks --

CHAIRPERSON TURNER-BAILEY: Actually you're not.

MR. HOROWITZ: Two comments and really (inaudible). Long-term care. I would just point out to you that we just heard an instance in which someone is saying that patterns of utilization are a better way of grouping a facility, provider facilities, than county boundaries. I just want to point that out in the context of our prior discussion this morning about subareas because that's what they're concerned about. Two, I would just say suggest that whatever this is about that causes a state representative whose grandfather I campaigned for in that district would be concerned about access in Monroe County. The state representative from north central Detroit be concerned about access in Monroe County. But I (inaudible) to be that far. I just want to point out and I'm sure it's just to be clear what Dr. Sandler so precisely said, the Commission just acted this morning for an amendment for the (inaudible). It's coming up for public hearing hopefully just shortly before May 11th. And this Commission wants to act on it on May 11th. I suggest to you that's your forum to figure out whatever this is and strongly suggest to you that you try to put together something that explains what precisely you want. They can't give you a waiver. There's no such thing in Michigan law. They can't amend state statute about census data or that section about that's outside their power, but you can change the
database to exactly actually how many people in Ohio are getting MRI scans who live in Michigan.

MS. ROLLINS: We've got the database.

MR. HOROWITZ: It's amazing to me because I don't anybody who collects it that way. But I'm only saying to you Virgie and --

MS. ROLLINS: We do. We have the database.

MR. HOROWITZ: I understand. That's the forum in which I would suggest you do then take it up with the Department and see if you can figure out what is it precise issue that you're trying to solve. Because they're getting one more fixed if this Commission action goes through the whole system. Then my final question. Could you tell us what now is going to be on the agenda for May 11th? This thing is evolved, we taking care of the things you couldn't get to otherwise but we seem to keep on putting stuff on there. So it would be hopeful if you could just say what's coming up on May 11th. If somebody has --

CHAIRPERSON TURNER-BAILEY: I don't think I can tell you that right now. Although the work plan is probably a good place to start. We're going to move to that meeting just like we would any regular --

MR. HOROWITZ: No, I thought there were certain things you deftly said you want taken up on that day. I know the Unity Health thing is one by Commissioner Delaney's motions, the MRI is -- what else is on that agenda. There was something that people had in mind. Maybe Brenda knows.

CHAIRPERSON TURNER-BAILEY: The special request for the advisory commission –

MR. HOROWITZ: You just added three things today. I'm trying to figure out what were the issues that prompted you --

COMMISSIONER SANDLER: I'll answer that. I had asked at a previous meeting --

MR. HOROWITZ: I'm not objecting it, I just don't remember.

COMMISSIONER SANDLER: I asked at a previous meeting a generic comment that we seem to have way too much business before meetings. We should schedule five meetings which was our recommendation, get them on everybody's calendar early on. And if we didn't have enough business it was just far easier to cancel a meeting than to try to e-mail all of us, what about these dates, no, I can't go through this. It was extra work for the Chair and extra work for the Department. And that was a

recommendation. Had I seen at the time I did this it was the impression of the (inaudible) such as when are we going to finish the MRI? We just couldn't get to because of the bed issues. So that was our rational on that.

CHAIRPERSON TURNER-BAILEY: There was a time we used to have meetings and be able to get through those within two to three hours so maybe that might be a --

MR. HOROWITZ: Is litho eligible to go up for final action? Was today proposed actions?

CHAIRPERSON TURNER-BAILEY: Today was the final action.

COMMISSIONER SANDLER: We only had final action.

MR. HOROWITZ: And the CT was final?

COMMISSIONER SANDLER: That is correct.

MR. HOROWITZ: Thank you.

COMMISSIONER SANDLER: We will address the representative of the representative. We hopefully will address final action possible on the fixed scanner for Monroe on May 11th.

CHAIRPERSON TURNER-BAILEY: It's just the whole MRI issue.

COMMISSIONER SANDLER: Correct. The whole MRI issue which includes Monroe.

CHAIRPERSON TURNER-BAILEY: Lody Zwarensteyn.

MR. ZWARENSTEYN:. Thank you. But I do rise to just express my shock, Dr. Sandler. There's an epidemic on the west side of Michigan. Apparently you've gotten some clandestine letters that we've never seen in west Michigan alleging an epidemic or something. I'm truly shock at this. And if there is such a problem that is coming about via letters that are not open to light of day, could I ask an offer that the service of the Alliance Health be used in west Michigan to actually shed the light of day on something like that before it comes here?

COMMISSIONER SANDLER: Would that be the light of -- the letters were distributed not to me but to the Commission.

MR. ZWARENSTEYN: I understand. But we haven't seen those --

COMMISSIONER SANDLER: All these urologists from west Michigan said they, probably that's the problem, cannot get shocked. You were shocked but they can't get shocked.(Laughter).

MR. ZWARENSTEYN: All I said is to you is that to our knowledge there is capacity on the existing equipment in west Michigan that capacity is not being stretched at all, there's been no change in the volume whatsoever suggesting there's no growth, there's no problem having access, scheduling delays if they are inferred, they usually are. Because the referring physicians says I don't want to come out at this time; It's rather a later time. But as far as we have heard thus far there really hasn't been a problem so that's why I just said I'm shocked to hear about –

MR. STYKA: I think it's parliamentary and I'd like to point out that when Commissioner Goldman left a few minutes ago you lost your quorum.

COMMISSIONER MAITLAND: So we have to go forever we can't -- (Laughter).

MR. STYKA: You can listen if you want to because you are adjourned.

COMMISSIONER SANDLER: You know Dr. Wise of Grand Rapids neurologist, okay, I'm going to have Collin or Brian of the (inaudible) Society talk to the urologists and suggest they talk. Thank you.

CHAIRPERSON TURNER-BAILEY: So since we don't have a quorum we're adjourned.

(Whereupon meeting was adjourned at approximately 3:06 p.m.).